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HEALTH PROFESSIONS REAUTHORIZATION ACT OF 1988

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

ON

S. 2229

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO REAUTHORIZE PROGRAMS CONCERNING HEALTH RESEARCH AND TEACHING FACILITIES, AND TRAINING OF PROFESSIONAL HEALTH PERSONNEL UNDER TITLE VII OF SUCH ACT, AND FOR OTHER PURPOSES

APRIL 28, 1988

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HEALTH PROFESSIONS REAUTHORIZATION ACT OF 1988

THURSDAY, APRIL 28, 1988

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 2:30 p.m., in Room SD-430, Dirksen Senate Office Building, Senate Spark M. Matsunaga presiding.

Present: Senators Matsunaga and Thurmond.

OPENING STATEMENT OF SENATOR MATSUNAGA

Senator **MATSUNAGA** [presiding]. The Committee will come to order.

I want to welcome everyone here to this hearing on the health professions education programs this afternoon. I am pleased to cosponsor S. 2229 with Senator Kennedy and will be chairing this hearing on legislation which reauthorizes programs in Title VII and continues targeted Federal support for the training of health professionals.

A new section has been developed for the allied health professions which addresses severe shortages in many of those professions.

The health professions programs in Title VII represent health manpower policy which has been carefully constructed over a period of more than 20 years in order to provide for changing national needs for a labor-intensive health care industry.

This legislation provides two kinds of assistance—institutional support in the form of grants and contracts for schools that educate health professionals, and student assistance in the form of loans, loan guarantees and scholarships for students enrolled in these schools.

These programs were first authorized 24 years ago and are as essential today as when they were first authorized. These programs intend to correct problems in the supply and distribution of health personnel and to better meet the current and future health care needs of our Nation.

Increased support is proposed in several priority areas, including allied health, geriatrics, minority representation in the delivery of health care and primary care training.

A new program has been included to address the Nation's severe allied health provider shortage. The shortage of physical therapists, occupational therapists, respiratory therapists, speech and hearing therapists, and other practitioners has hit crisis levels among hospitals, nursing homes, home health agencies, rehabilitation centers and hospices. These shortages seriously compromise quality health care for the elderly and other Americans. These therapists are essential to care for the elderly and chronically ill, the disabled, handicapped children, and AIDS patients. These shortages are predicted to intensify for the remainder of this decade and through the year 2020.

As the Chairman of this Committee's Subcommittee on Aging, I am acutely aware of the importance of training in geriatrics for students in the health professions. Physicians, dentists, allied health practitioners and other health professionals need improved and expanded training in geriatrics in order to provide high-quality health care to the rapidly growing elderly population.

Development of faculty to teach in this vital area is also essential. This legislation establishes a new section to support geriatric education centers and geriatric faculty training.

In considering the reauthorization of Title VII, my colleagues and I are faced with a dilemma: How can we best address the problem of these shortages in allied health fields, the under-representation of minorities, and the lack of primary care physicians during these times of tremendous deficits and limited growth in the Federal budget.

Again, I welcome you all and thank you for coming. I look forward to hearing your ideas and suggestions today on these matters. I hope you will continue to work with us on S. 2229, to see this bill passed by the Senate and the House, and signed into law by the President.

In order that witnesses may have a full opportunity to respond to the questions from members of the Committee, I would appreciate witnesses limiting the oral testimony to no more than five minutes. The text of your complete written testimony will be included in the record, which will remain open for 48 hours after the hearing. In the case of the Administration, we will make an exception to that five-minute rule and allow ten minutes.

At this point we will submit for the record a summary of the bill and also statements for the record by Senators Hatch and Simon.

[The summary referred to and statements of Senators Hatch and Simon follow:]

A summary of
PHS TITLE VII REAUTHORIZATION: HEALTH PROFESSIONS EDUCATION,1988

The reauthorization of Title VII, programs concerning training of health professions, contains sections on loans and scholarships for health professions students, capitation grants to schools of public health, grants to support training in family medicine, general internal medicine and pediatrics, preventive medicine, area health education centers, support for training in allied health, health administration, and several special project grants programs. In 1984, reauthorization was considered and vetoed by the President. A revised version was signed by the President in 1985. A total of $153.67 million was appropriated in FY 88. The proposed FY 89 authorization is $227.5 million.

We emphasize support for primary care training programs (family medicine, general internal medicine and pediatrics), geriatrics, increasing grants and loans to students in health professions schools, increasing funds for recruitment and retention of minority students, and training programs for the allied health professions. Reauthorization with the following revisions in Title VII and funding levels for FY 89-91:

Student Assistance

Changes include reducing the compounding of interest to lower the repayment amount, clarifying the bankruptcy provisions, and allowing for loan repayment should a medical school graduate pursue a career in academic medicine, and increasing the ceiling on the federal loan guaranteed amount for the Health Education Assistance Loan (HEAL) PROGRAM.
Health Professions Student Loans authorized at $15 million in FY 89, $16 million in FY 90, and $17 million in FY 91. These are low interest loans, unlike the high interest Health Education Assistance Loans. Funds were last authorized in FY 84.
Scholarships for Students of Exceptional Financial Need received $6.7 million in FY 88; eligibility increased for students in all four years of medical, dental and osteopathic schools; $25 million for each of the FY 89 to FY 91 years.
Public Health Traineeships continued at the FY 88 level of $5 million per year.

Capitation Grants to Schools of Public Health

Continue at $5 million for FY 89, $6 million for FY 90, and $7 million for FY 91.

Grants for Family Medicine

Increase funding levels from $7 million in FY 88 to $12 million in each of FY 89-91; grants to support family medicine and general dentistry residency programs will be increased from $39 million in FY 88 to $50 million in each of FY 89-91, with the set-aside for general dentistry increased from 7.5 percent to 15 percent of the total amount authorized in this section.

Grants for Training in General Internal Medicine and Pediatrics

Maintain the FY 88 level of funding for each of FY 89-91 at $22 million.

Area Health Education Centers

Provide diminishing funding for those AHECs currently receiving federal funding; provide $2 million per year for start-up of new AHECs; provide $2 million per year for current or old AHEC's to increase the number of health care providers in shortage areas; provide $3 million per year for programs to train personnel to offer maternal and child health services and child health services in shortage areas. Preference will be given to "border" states and frontier areas. Authorization comes to $23 million in FY 89, $ 24 million in FY 90, and $19 million in FY 91.

Educational Assistance to Individuals from Disadvantaged Backgrounds

Authorized for $30 million in FY 88: increase to $32 million in FY 89, $34 million in FY 90, and $36 million in FY 91. The current requirement for 20 percent of the amount appropriated to go for Exceptional Financial Need Scholarships, would be changed to require 20 percent of funds to go for student stipends within the **Health Career Opportunity Program** grants provided for under this section; a "performance requirement" to increase enrollment of minority students during a grant period to be eligible for subsequent grants is added.

Special Projects

The section is revised to break-out geriatrics; the remainder of the grant program continues for curriculum development and interdisciplinary training and includes preventive medicine and physicians assistants with simplified language; authorized at $9 million for FY 89-91; 20% of funds designated for two year schools.

Geriatric Education Centers and Geriatric Training

Geriatric training authorized at $12 million for FY 89; $14 million for FY 90; and $16 million in FY 91. Geriatric Medicine training projects, post doctoral dental education program authorized for $10 million in FY 89; $12 million in 90; and, $14 million in FY 91.

Personnel in Health Administration and in Allied Health

Because of severe shortages of allied health professionals, as discussed in the recent IOM study, and no funding since 1980, the sections of allied health are revised to provide for faculty development, assistance to doctoral students, data collection, and educational program development. Authorized for $11.5 million in FY 89; $14.5 million in FY 90; and, $17.5 million in FY 91. Health Administration training is authorized for $1,500,000 for each of the fiscal years 1989 through 1991.

S. 2229

Title Vll by Fiscal Year in Millions of Dollars

Health Professions	Appro. P.L.100-202 **FY88**	Authorization to be Appropriated **FY89**	**FY90**	**FY91**
Health Education Assistance Loan (HEAL)	(305)			
Health Professions Student Loans	0	15	16	17
Scholorships for Exceptional Financial Need	7	20	20	20
Public Health Traineeships	3	5	5	5
Capitation Grants to Schools of Public Health	5	5	6	7
Family Medicine Departments	7	7	7	7
Family Medicine/ Gen. Dental Res. and Trg.	35	41	41	41
Gen. Internal Med. and Peds.	18.5	22	22	22
Area Health Education Centers	18	2[illegible]	21	16
Ed. Assist. To Individuals from Disadvantaged Backgrounds	27	30	32	34
Special Projects: Curr.Dev., Prev. Med. Res., and Phys. Assistants.	18.5	8	8	8
Geriatric Education Centers/Trg.	0	10	12	14
Geriatric Medicine Trg. Proj.	0	10	12	14
Personnel in Health Administra.	1.5	1.5	1.5	1.5
Allied Health Education	0	15	20	24
Totals	$154.	209.5	223.5	230.5

STATEMENT OF SENATOR ORRIN G. HATCH

at the hearing on

Health Professions Reauthorization

April 28, 1988

Mr. Chairman, I am pleased we are holding today's hearing on Title VII of the Public Health Service Act -- the section entitled "Health Research and Teaching Facilities and Training of Professional Health Personnel." My only regret is that we did not hold these hearings several months ago to give this Committee more time to work on reauthorizing the important programs administered in conjunction with this section.

The health manpower programs contained in Title VII, while small in dollar amount, are of critical importance in our struggle to meet the health manpower needs of our nation. The members of this Committee realize that we have limited resources. Title VII appropriations for fiscal year 1988 were approximately $155 million. This compares to the estimated 1988 expenditures of $2 billion that will be spent for indirect medical education cost and the $1 billion that will be spent for direct medical education cost through Medicare this year.

Clearly, this Committee must prioritize and carefully consider how to spend every one of these precious dollars if we are to have an impact on our nation's health manpower needs. We must balance a broad range of interests and needs. The needs of everyone concerned, from chiropractors to podiatrists, allied health professionals to physicians, and dentists to veterinarians must be considered.

The Committee is faced with several options for reauthorizing these programs. We have Senator Kennedy's proposal, which would maintain most existing programs and add several new programs. We could simply continue to fund the existing programs with a few modifications. Or, we could adopt the Administration's proposal to convert these programs into a block grant, thus giving more flexibility to the states to address their individual health manpower needs. While we all agree that the Administration's recommended authorization level is unrealistic, the concept at least deserves some consideration.

I want to take this opportunity to clairify my position. My lack of support for any one of these proposals should not be interpreted as a lack of support for reauthorizing these programs. I fully support these programs, and hope that we will be able to pass a three year reauthorization during this Congress.

I look forward to reviewing the testimony presented today, along with the hearing record from the House, and the soon-to-be released report of the Council on Graduate Medical Education. I particularly want to review what our witnesses have to say about the following items: (1.) What they believe are the most pressing health manpower needs of this nation over the next three years, (2.) Which current federal programs will help us meet these needs, (3.) Which programs will not; and, (4.) Whether they believe their feelings about the Administration's proposal to convert these programs into a block grant would be effective.

Once this review process is complete, I look forward to working with my colleagues on reauthorizing these important programs.

I am particularly pleased that we will hear today from Dr. Cecil Samuelson, Dean, School of Medicine, and the Acting Vice President of the Health Sciences Center at the University of Utah. And, as always, it is a pleasure to see Dr. David Sundwall, the former Health Staff Director of this Committee. I know that their testimony and the testimony of the other witnesses will be of great value to the Committee as we struggle to find the most effective mechanism for reauthorizing these important health programs.

Statement of Senator Paul Simon

before the

Senate Committee on Labor and Human Resources

April 28, 1988

Hearing on S. 2229,

The Health Professions Reauthorization Act

Mr. Chairman, I would like to speak in support of S. 2229, the Health Profession Reauthorization Act. I thank the distinguished Chairman of the Committee for his leadership in this area and I am proud to be a cosponsor of the legislation.

It is important that all citizens have quality medical care available when they need it. In order to achieve that goal, there must be a sufficient supply of well-trained health professionals. As several of today's witnesses will testify, our country could be facing a shortage in important areas of practice in the next decade. S. 2229 is a timely step toward preventing a shortage by recruiting and educating health care providers.

In this bill, we are finally recognizing the allied health professionals. This important group has been habitually neglected in educational assistance. S. 2229 authorizes funds for recruitment of young people into the allied health professions. In addition, it provides for education improvement projects, faculty development and data collection.

As some medical specialties continue to grow, family practice is one area where a shortage is expected. Because of their broad training and ability to treat a variety of ailments, general practitioners are sought after for underserved areas. However, as has been pointed out here today, medical practice should be influenced by the medical schools, not by restricting residencies. S. 2229 wisely supports residency programs in family medicine and general dentistry.

This legislation focuses on areas of medical practice which require support. Besides family medicine, S. 2229 authorizes grants for training in internal medicine and pediatrics. These three areas, family medicine, internal medicine and pediatrics, account for more than half of all office visits. Clearly this bill assists those specialties with which most people deal. A growing shortage in these groups would lead to a serious erosion of accessible, quality health care.

Mr. Chairman, I would like to thank you and thank the witnesses who appeared today. I am proud of the steps that S. 2229 takes to prevent a medical crisis in the near future.

Senator MATSUNAGA. I see that Senator Thurmond is here. Do you have an opening statement, Senator?

Senator THURMOND. Yes, Mr. Chairman.

Senator MATSUNAGA. Please proceed.

OPENING STATEMENT OF SENATOR THURMOND

Senator THURMOND. Mr. Chairman, I wish to commend you on conducting this hearing on programs concerning health research and the training of professional health personnel under Title VII of the Public Health Service Act.

I am looking forward to receiving this testimony today about these important programs, and although I cannot remain, I will review this testimony.

Mr. Chairman, I would like to bring to the Committee's attention two important areas of this reauthorization Act. First, Title II of this legislation provides for the reauthorization of capitation grants to improve the quality of schools of public health in the United States. The capitation grant program is one of our Nation's oldest Federal higher education programs. It provides financial assistance in the form of formula grants to accredited schools of public health for the support of educational programs.

In my State, there is only one school of public health, which is located at the University of South Carolina. The school admitted its first class in 1975 and to date has produced 650 graduates. Degrees are offered by this institution in biostatistics, environmental health sciences, epidemiology, health administration, as well as health promotion and education.

The University of South Carolina School of Public Health relies heavily on capitation grants to supplement State support, which amounts to 65 percent of its total budget. Thirty percent of the salaries of faculty at the University of South Carolina's School of Public Health are paid in part or in full with capitation funding, and 60 percent of the school's part-time faculty salaries are derived from capitation. Also, approximately 50 percent of the school's teaching equipment is paid for with funds from this source.

Officials at the University of South Carolina have informed me that without continued capitation assistance, the School of Public Health will not be able to adequately fulfill its important mission in my State. Capitation funding has allowed this relatively new school to attract and retain an outstanding faculty, procure state-of-the-art equipment, conduct community service programs, recruit minorities to the public health profession, and support research.

Clearly, the capitation grant program plays an important role in training professionals in the field of public health at the University of South Carolina and in the 23 other accredited schools of public health in the United States.

Second, Title III of this Act authorizes programs to provide funding for medical facilities to establish residency training positions in programs which are designed to expand the availability of family medicine practitioners and general dentists in medically underserved rural communities.

In South Carolina, there is a demand in rural areas for primary care physicians and dentists. Family medicine practitioners and general dentists are able to treat a wide variety of cases, thereby decreasing the need for referral of patients to specialists who are located in areas distant to rural communities.

Funding authorized by this Act has allowed two medical facilities in South Carolina to establish general dentistry residencies. The Medical University of South Carolina in Charleston received Federal general dentistry funding from 1978 to 1980, and Richland Memorial Hospital, in the State's capital, received general dentistry funding from 1984 to 1986.

Both of these institutions have expressed a need to expand their resident training positions. Also, hospitals in Greenville and Florence, South Carolina have indicated an interest in establishing general dentistry resident programs in their areas.

There is a definite need for general dentistry residency programs in my State. However, there are presently no non-military general dentistry residencies being funded in South Carolina under the provisions of Title III of this Act. I have been advised that this situation exists due to a lack of availability of Federal funding in this area.

Mr. Chairman, when we hear from these witnesses today, I will be particularly interested in their views about these programs. While my schedule will not permit me to stay for the entire hearing, I look forward to reviewing the testimony that is presented.

Thank you very much, Mr. Chairman.

Senator **MATSUNAGA**. Thank you, Senator Thurmond, for your opening remarks.

Our first panel consists of two witnesses. We will hear first from Dr. David Sundwall, who is the Administrator of the Health Resources and Services Administration.

We would be happy to hear from you now, Dr. Sundwall.

STATEMENTS OF DR. DAVID SUNDWALL, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, WASHINGTON, DC, ACCOMPANIED BY DR. JARRETT CLINTON, DIRECTOR, BUREAU OF HEALTH PROFESSIONS; AND DR. NEAL VANSELOW, VICE PRESIDENT FOR HEALTH SCIENCES, UNIVERSITY OF MINNESOTA, MINNEAPOLIS, MN, ON BEHALF OF COUNCIL ON GRADUATE MEDICAL EDUCATION, ACCOMPANIED BY PAUL SCHWAB, EXECUTIVE SECRETARY, COUNCIL ON GRADUATE MEDICAL EDUCATION, AND DEPUTY DIRECTOR, BUREAU OF HEALTH PROFESSIONS.

Dr. **SUNDWALL**. Thank you, Mr. Chairman.

I am delighted to be here, and Senator Thurmond, after your excellent introductory remarks, you have kind of stolen my thunder; I was going to talk about the good things in Title VII over the years, but I think I will skip some of the history, because you obviously know it very well.

I have with me Dr. Jarrett Clinton, to my left, who is the new Director of the Bureau of Health Professions. If you have specific or difficult questions, I am going to ask him to answer them.

But let me proceed to give a summary of my remarks, and then we will submit for the record a more complete document.

Senator **MATSUNAGA**. Fine.

Dr. **Sundwall.** The health professions educational assistance authories in Title VII of the PHS Act are now some 25 years old, having had their beginnings in 1963. The authorities have been amended and changed over time. Their initial goal was to increase the number of health professionals, particularly physicians. With that goal, the authorities were very successful; all kinds of health providers were educated in much greater numbers than when these authorities were first begun.

When the numbers were increased, however, the authorities were modified so they focused on particular needs such as primary care training—there are still deficiencies in some areas—improving the health personnel in rural and other underserved areas, and geriatric training.

Under Title VII, the Federal Government since the mid-1960s has spent about $5.8 billion. Just since the mid-1970s, the investment has been over $2.3 billion. Most of these funds have been distributed through a series of categorical authorities, or grant programs, to respond to train particular health professionals or to address the needs of a particular population.

The Federal investment in health professions programs has been accompanied, we are pleased to report, by a major growth in interest of State, local and professional organizations in the development of these programs. We believe that that cooperative effort is essential. The Federal Government alone cannot begin to meet all of the needs. Also, when the professional groups and local communities and governments become involved, they can tailor programs to meet the needs of their particular communities.

With most of HRSA's health professions and nursing education authorities in Titles VII and VIII needing to be reauthorized this year, the Administration stepped back and took a look at what we might do in an alternative fashion to address the health professional needs of the country.

On the basis of our review of projected needs and resources, we are proposing that the existing health professions education authorities in Titles VII and VIII of the Public Health Service Act be replaced by a unified comprehensive authority for grants to or cooperative agreements with States and public or private entities, or combinations thereof, for projects which will meet high-priority health professional needs.

In recent years, the multiple special-purpose categorical authorities, we believe have constrained the ability of the Federal Government to work freely with States and other entities in using limited resources available for health profession initiatives of greatest need.

For example, a number of categorical authorities like AHECs, public health training, geriatric training, and exceptional financial need, scholarships, are written in such a way that States and local governments cannot apply for assistance or collaborate in a direct way.

Given these constraints, the philosophy behind the Administration's proposed cooperative health professions initiative authority is that the Federal Government can best utilize limited resources to accomplish national priority health personnel objectives under a flexible authority that will allow adaptation to changing needs.

Flexibility is needed to deal with emerging health care issues, adjust to new developments in curriculum, and avoid the need for technical amendments to overly-rigid authorities.

Within the proposed broad authority, special areas of emphasis would be promoted. Initially, for example, we would favor focusing our health profession resources to assist disadvantaged students, to enhance training opportunities in rural or other underserved areas, to improve the supply and distribution of primary care providers, to increase training of nursing personnel, and to strengthen the training we now have in geriatric care.

In addition to proposing the cooperative health professions initiatives which I have just described, we plan to continue the Health Professions Student Loan [HPSL] Program. School loan funds established under this program will continue to be allowed to use amounts repaid by former borrowers to make new loans to exceptionally financially needy students on a low-interest basis. In fact, we estimate for the fiscal year 1989, 22,400 students will be able to receive loans totalling $56 million from these revolving funds.

The Administration would also extend for three years the authority to ensure Health Education Assistance Loans, or HEAL loans, at a level not to exceed $100 million of borrowing each year.

In recent months, our agency has taken on a number of actions that we think will have a positive impact on these loan programs by going after defaulting students and strengthening our recovery of loans.

On November 12, 1987, the Department submitted to Congress a draft bill entitled the "Health Professions Loan Amendments of 1987." This draft bill proposes a number of reforms in the HEAL and HPSL programs designed to strengthen the management of the programs. We are pleased that several of those amendments are incorporated in your legislation, Mr. Chairman, S. 2229, and hope that the Committee will consider still other proposals which we will submit along with the Cooperative Health Professions Initiatives proposal.

In conclusion, I can assure you that we do look forward to working together with this Committee to make sure that the Federal efforts in health professions go a long way toward addressing the needs of our country.

I would be happy to answer any questions you might have, now or after Dr. Vanselow's testimony.

Senator MATSUNAGA. Thank you very much, Dr. Sundwall.

[The prepared statement of Dr. Sundwall follows:]

STATEMENT BY

DAVID N. SUNDWALL, M.D.

ADMINISTRATOR

HEALTH RESOURCES AND SERVICES ADMINISTRATION

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

APRIL 28, 1988

Mr. Chairman and Members of the Committee:

I am pleased to appear before you today to discuss issues relating to the reauthorization of the health professions education authorities in Title VII of the Public Health Service (PHS) Act. I am accompanied by Dr. Jarrett Clinton, who recently became the director of the Bureau of Health Professions of our Agency.

The legislative authorities under review today have had a distinguished history. Beginning with the Health Professions Educational Assistance Act of 1963, a series of at least seven major laws and numerous additional amending statutes have provided the framework for Federal support to expand the supply, enhance the quality, and improve the distribution of physicians, dentists, and other health professionals to provide needed health services.

Over the years, the details of the authorities have changed as the health personnel needs have changed. At first, the main objective was to increase overall supply as necessary to keep pace with population growth. Later, when overall supply goals had been largely met, attention turned to more specific objectives such as increasing the number of primary care providers, assisting students from disadvantaged backgrounds, and improving health personnel supply in rural and other underserved areas.

Under the Title VII health professions education programs, the total Federal investment from the mid-1960's through fiscal year 1987 has been about $5.8 billion. Since 1976, the investment has been over $2.3 billion. Most of these funds have been distributed under a series of categorical legislative authorities created over the past 25 years in an effort to respond to needs for health professionals to provide specific health services to particular groups of people.

Federal investment in health professions programs has been accompanied by major growth in State, local, professional, and other non-Federal involvement in the development and operation of these programs. Today, it is essential that non-Federal entities contribute to the resolution of differing personnel needs in various parts of the country. We need this non-Federal involvement not only to ensure relevance of programs to local needs as perceived by those familiar with the issues, but also to increase the prospects for long-term financial viability of programs initiated with Federal aid.

With most of HRSA's health professions and nurse education authorities in Titles VII and VIII of the PHS Act scheduled to expire at the end of FY 1988, the Administration has reviewed alternative ways of authorizing Federal health professions activities to encourage cooperation and collaboration between Federal and non-Federal organizations in the resolution of issues. We have considered the alternatives in the light of prevailing limits on overall Federal spending for health and related programs.

On the basis of our review of projected needs and resources, we are proposing that the existing categorical health professions education authorities in Titles VII and VIII of the Public Health Service Act be replaced by a single comprehensive authority for grants to, or cooperative agreements with, States and public or private entities, or combinations thereof, for projects to meet high priority health personnel needs. This proposal has been described in the President's Budget for FY 1989. A draft bill will be sent to you in the near future.

In recent years, as progress has been made in meeting health personnel needs, the multiple special-purpose categorical authorities have constrained the ability of the Federal Government to work freely with States and other entities in using limited resources available for health professions initiatives in the areas of greatest need. To illustrate:

- A number of the categorical authorities are written in such a way that State and local governments cannot apply for assistance. Examples include the Area Health Education Center program authority, the two geriatric training authorities, the Exceptional Financial Need Scholarship authority, and the public health training authorities. The Area Health Education Center program authority has needed amendments repeatedly over the years to modify rigid statutory requirements.

- There are separate authorities for support of departments of family medicine, for training of physicians in general internal medicine and general pediatrics, and for training of physicians in family medicine. Each of these authorities has its own appropriation line item (or items), regulations, eligibility requirements, peer review process, and funding preferences. Yet, from the viewpoint of most health services recipients and many health care facilities, all of the programs have one goal: providing an adequate number of well-trained primary care physicians.

Given these constraints, the philosophy behind the Administration's proposed Cooperative Health Professions Initiatives authority is that the Federal Government can best utilize funds to accomplish national priority health personnel objectives under a flexible authority that allows adaptation to changing needs. Flexibility is needed to:

- give maximum discretion to States or other non-Federal entities to tailor initiatives to address their particular needs;
- deal with emerging health care issues, such as new diseases or new supply misallocations;
- take account of variations in the availability of non-Federal resources by geographic area or type of training;
- accommodate changes in related Federal programs;
- adjust to new developments in curriculum emphasis; and
- avoid the need for "technical amendments" in overly rigid legislative authorities.

Any project supported under this proposed authority would be required to address documented health care needs, have a plan for becoming independent of Federal financial assistance, and involve appropriate State health and educational entities.

Within the proposed broad authority, special areas of emphasis would be promoted. Initially, for example, we would favor focusing health professions resources to:

- provide assistance to disadvantaged students,
- increase the training of nurse specialists,
- enhance training opportunities in rural or otherwise underserved areas,
- improve the supply and distribution of primary care providers, and
- strengthen training of health providers in geriatric care.

In summary, the proposed Cooperative Health Professions Initiatives authority would provide the flexibility needed to encourage States and public and private entities to enter into cooperative arrangements to address health professions issues and to invest their own funds in the solution of these problems. In addition, we would continue operation of the Health Professions Student Loan program and the Health Education Assistance Loan, or HEAL, program as authorized in Title VII.

School loan programs established under the Health Professions Student Loan authority could continue to use amounts repaid by former borrowers or otherwise available under the program to make loans at low interest rates to students of exceptional financial need. In fiscal year 1989, it is estimated that approximately 22,400 students will receive loans totaling $56 million from these revolving funds.

Under 1985 amendments, excess Health Professions Student Loan funds which are returned by schools to the Secretary in any fiscal year shall be redistributed in that fiscal year and the succeeding fiscal year to eligible schools who request funds. Included in the total of $56 million estimated to be available for health professions student loans in fiscal year 1989 is a portion of the $3.7 million that is expected to be available for redistribution as a result of program terminations or other reasons.

The Administration would extend for three years the authority to insure new HEAL loans from non-Federal lenders at a level not to exceed $100,000,000 each year. Over the past several years, our Agency has made determined efforts to improve the administration of the HEAL program. Several actions are underway that will have a direct impact on future claims on the Federal Government for defaulted loans. These include aggressive enforcement of revised regulations, the conduct of national workshops for schools and lenders, reviews of school and lender operations, and a study to identify key characteristics of defaulters.

One issue in administration of the HEAL program is the extent to which a lender is required to use litigation against a defaulted borrower before filing a claim against the Federal Government. Under regulations issued last year and under the terms of a recently signed Memorandum of Understanding with the Student Loan Marketing Association (Sallie Mae)--the largest holder of HEAL loans--litigation will now be used under specified conditions.

On November 12, 1987, the Department submitted to the Congress a draft bill entitled the "Health Professions Loan Amendments of 1987." This draft bill proposes a number of reforms in the HEAL and HPSL programs designed to strengthen the management of the programs and to make them more cost-effective. We are pleased that several of our proposed loan amendments have been included in S. 2229 and hope that the Committee will consider still other proposals from that submission along with our Cooperative Health Professions Initiatives proposal.

We would note that many health professions students are eligible for additional types of federally subsidized student assistance (Perkins Loans and Guaranteed Student Loans, among others) under general student assistance programs of the Department of Education.

In conclusion, Mr. Chairman, I appreciate the opportunity to share with you our views on reauthorization of the health professions authorities. I hope that we will be able to work together to extend these authorities in a way that will allow the Federal Government to continue a constructive role in assisting to resolve major public issues in this field.

I would be glad to answer any questions.

Senator **Matsunaga**. Dr. Sundwall, the Administration has proposed a $40 million State block grant for health professions to replace the current $212 million funding for categorical programs under Titles VII and VIII. This represents a significant decrease despite the Administration's recognition of shortages in allied health and nursing.

In addition, I feel that some States might be less than responsible in carrying out the programs as in Medicaid. This represents an improvement over the previous Administration request for no funding. But do you really expect this Committee to take your request seriously?

Dr. **Sundwall**. Sir, I don't expect you to embrace the entire Administration proposal as we have presented it to you, but I do believe there is merit in the philosophy behind it.

I would like one correction in how you describe the Administration's proposed authority. The authority does not call for block grant to States. Funds could go to States or to medical schools or consortia of medical schools, groups of medical schools. We believe that if at the local level, the schools and the States would really try to figure out what the health personnel needs are in their region, our money might be better spent, whether it be for geriatric training, nurse education, rural health personnel, or primary care training. We need to get local communities more involved.

So the intent behind our proposal is, I believe a very positive one. The amount of money authorized is limited. And my answer to that is we have tough times and hard choices, and you have the same decisions to make all the time.

Senator **Matsunaga**. Dr. Sundwall, how effective has the Area Health Education Center Program been in facilitating physicians and other health professionals choosing to practice in underserved areas?

Dr. **Sundwall**. Well, this has been studied in certain AHEC regions, and we have found the program to be very successful indeed. A good example is the State of North Carolina, which has succeeded not only in training young health professionals in rural and underserved areas, but in having them choose to work and stay there. So that particular way of conducting education of health professionals, I think, is a very good one.

In fact, I believe our Cooperative Health Professions Initiatives activities could be patterned after the AHEC kind of activity.

Senator **Matsunaga**. I am aware of the recent study on the effectiveness of Federal support for general internal medicine and general pediatric residency programs. Are there other examples of evaluations of grant programs administered by the Health Resources and Services Administration?

Dr. **Sundwall**. Yes, there are. Three major studies of aspects of the family medicine training program have been completed. I would be glad to provide for the record the specific results of those studies. I think you will find them useful.

Senator **Matsunaga**. We would appreciate it for the record–and lest I forget, your full statement will appear in the record as though presented in full.

Dr. **Sundwall**. Thank you, Mr. Chairman.

[Information supplied follows:]

Results of Studies Evaluating Family Medicine Training Programs

Three studies evaluating programs undertaken under the Family Medicine Training authorities in Section 786(a) of the Public Health Service Act have been completed, as follows:

- Impact of Federal Support on Family Practice Residency Training (Completed 5/30/85) Cost: $196,186
- Impact of Federal Support on the Family Medicine Predoctoral Training Program (Completed 8/11/86) Cost: $184,235
- Assessment of the Development and Support of the Family Medicine Faculty Development Program (Completed 12/30/87) Cost: $134,705

The objectives and outcomes of these studies are described below.

Impact of Federal Support on Family Practice Residency Training

The objective of this study was to evaluate effects of Federal support through the Family Medicine Residency Training Program on (1) the numbers of residents, (2) content of training, and (3) practice location of graduates.

Study outcomes were:

- Positive association between level of Federal funding and total numbers of family practice residents
- Some association between funding continuity and number of residents produced (continuously funded programs had higher proportions of women and minorities)
- Revenue/cost ratios of family practice residency programs vary directly with Federal funding (confirms concept of grant funds being last dollar funds)
- Some positive association (supported primarily through case study findings) between Federal funding and academic character of residency programs, i.e., student/faculty ratios, number of months in specialty rotations, number of programs with fellowship and fourth year positions.
- Impact of loss of Federal support is function of organizational structure (large university-based programs have more alternative revenue sources)
- No definitive trends in practice site selection relative to funding (percent selecting inner city practice sites increased among all programs, but heavily-funded programs had most rapid increase)

Impact of Federal Support on the Family Medicine Predoctoral Training Program

The objective of this study was to evaluate effects of Federal support through the Predoctoral Training Programs on (1) undergraduate curricula, (2) content and environment of clinical training, (3) organizational structure of family medicine units, and (4) number of graduates electing family medicine residencies.

Study outcomes included:

- Number of family medicine graduates increased over study period (1978-1984) as did regular and volunteer faculty
- Larger institutions are more significant sources of family medicine graduates
- Effects of predoctoral training grants on number of family medicine graduates are mixed. Some evidence of a relationship between total trainee stipends and increases in numbers.
- Clear association between receipt of grants and increase in number of departmental faculty
- Case studies indicate that grants have had positive impact on acceptance by other departments' faculty of family medicine as a specialty, on addition of nonmedical specialists, on attractiveness of specialty to students through clerkship/preceptorship experiences, and on incorporation of elective courses in family medicine into the general curriculum

Assessment of the Development and Support of the Family Medicine Faculty Development Program

The objective of this study was to assess the effects of Federal and private sector financial support of faculty development programs on (1) increasing the supply of physician faculty available to teach in family medicine programs and (2) enhancing the pedagogical skills of existing faculty through improved program content and trainee development.

Study outcomes included:

- Positive association between the level and continuity of Federal funding and numbers and mix of faculty trained (highly funded programs trained significantly more fellows and full time faculty)
- Positive association between level of Federal funding and program longevity/stability (program expiration decreases as intensity of funding increases)
- Sense of institutional support along with stability and respect of family medicine program leadership are crucial to program success
- Training in pedagogical skills not the sole focus of faculty development (competencies in research, administration, communication, etc., also required in academic settings)

Senator MATSUNAGA. In your view, how effective has the Health Careers Opportunity Program been in stimulating the enrollment and graduation of minority students from health profession schools?

Dr. SUNDWALL. That is a difficult question to answer. In general, let me just say at the outset that we are all disappointed that the numbers and percentages of minority applicants and students matriculated in our health professional schools have not been growing as much as they might; in fact, there have been some slight decreases over the past decade. We have that information broken down by particular minority groups and particular types of schools, whether they be dentistry or podiatry or medicine. So we are unhappy with the results obtained.

One study indicates that the schools that do have an HCOP program have had a larger-than-average increase in their minority enrollments. So there is, albeit somewhat disappointing, nonetheless some positive indication that the HCOP programs do facilitate more minorities' enrolling.

Senator MATSUNAGA. Dr. Sundwall, existing studies and opinions of leading health manpower experts point to several public health occupations with personnel shortages. There are shortages of epidemiologists, environmental health professionals, biostatisticians, nutritionists, public health nurses and physicians trained in public health and preventive medicine. What is the Administration doing to meet these needs, and what steps is it taking to assist the schools of public health in training professionals to fill the shortages?

Dr. SUNDWALL. If you don't mind, sir, I'd like to have Dr. Clinton, who is a physician educated in public health, respond to that.

Senator MATSUNAGA. Dr. Clinton?

Dr. CLINTON. You are quite correct, Senator, that there are shortages of personnel in a number of the public health areas. Our fifth report to the Congress on the status of health personnel documented those shortages, and our forthcoming sixth report, which should reach the Congress in the next month or so, will document it further.

We have provided over $100 million to schools of public health in the last ten years, so we believe there has been a substantial Federal involvement in schools of public health.

But as you pointed out earlier, and as we have heard from Senator Thurmond, much of that Federal support has been in the form of capitation grants, which has limited our capacity to focus money on specific shortage areas. We would welcome an opportunity, through proposed the Cooperative Health Professions Initiatives Authority, to give greater assistance to epidemiology, environmental health care, or whatever other specially a local area felt was particularly important. We have no way to influence the way the capitation grants are utilized by schools of public health.

We have funded a number of contracts in the field of public health training and, within the resources available to us, will continue to look at specific issues such as recruiting additional people into the field of epidemiology. Currently, we are examining the health professions work force generally in terms of environmental health issues, including Superfund problems, toxicity problems in our neighborhoods, and related environmental problems.

Senator **Matsunaga**. Thank you very much, Dr. Sundwall and Dr. Clinton.

If you prefer to leave before I call on the next panel of witnesses, you may do so. On the other hand, I would prefer that you remain and listen to the other witnesses. Perhaps they may convince you that what the Administration is trying to do may not be the right thing.

Dr. **Sundwall**. Mr. Chairman, I will certainly stay and listen to Dr. Vanselow and this panel. I have to catch a plane for the West Coast, where my son is waiting to meet me, and I hate to stand him up. So I will have to beg your indulgence as I leave to catch a plane.

Senator **Matsunaga**. We will be sure that you get a copy of the hearing record so that you will know what the witnesses have said.

Dr. **Sundwall**. Thank you, and I promise to read the testimony.

Senator **Matsunaga**. Thank you for coming. We appreciate it.

Now, we will hear from Dr. Neal Vanselow, who is the Vice President for Health Sciences at the University of Minnesota. We are happy to hear from you, Doctor.

Dr. **Vanselow**. Thank you, Mr. Chairman.

I am pleased to be here today to testify, and my testimony will be presented on behalf of the Council on Graduate Medical Education.

I have brought with me today Mr. Paul Schwab, who is on my right, who is the Executive Secretary of our Council and also is the Deputy Director of the Bureau of Health Professions.

Before I get into the substantive areas that I would like to comment on, let me just tell you a little bit about our Council and its activities.

The Council on Graduate Medical Education was established by Congress in April 1986. We have a ten-year life span. Our first report to Congress is due July 1st, 1988, and we will issue reports every three years thereafter. We are advisory, not regulatory. We are to advise the Congress and the Secretary of Health and Human Services in three major areas. First of all, physician manpower—that includes the supply of physicians, both in the aggregate and by specialty, and also on physician distribution. The second area is foreign medical graduates, and the third is the area of graduate and undergraduate medical education. Our first report will concentrate on the financing of graduate medical education.

We have 17 members on the Council, 3 Federal officials, and then there are 14 private citizens appointed by the Secretary. The latter are broadly representative of physician groups, of medical schools and teaching hospitals, business, labor, the health insurance industry, students, and so on.

We have had five meetings to date, Mr. Chairman. We have had a two-day public hearing. Because of time and budgetary limitations, we have not been able to collect our own primary data, but we have reviewed a great deal of data collected by others, and we have heard a great deal of testimony. We have reached a set of preliminary conclusions and recommendations. I must emphasize these are preliminary, because we will be meeting next week, Monday and Tuesday, to finalize these, and obviously, some things could change.

The first area I'd like to comment on would be the aggregate supply of physicians in the United States. Our Council has reached the tentative conclusion that if current policies and present trends regarding such things as access to health care continue, there now is or there soon will be an aggregate oversupply of physicians in the United States.

We do not believe, however, that it is possible to quantitate either the extent of this oversupply with any degree of precision or to predict how far into the future it will last. This is because of many variables on both the supply and the demand side of the manpower equation which are very difficult to measure.

Similarly, we believe that there is conflicting evidence as to whether this oversupply is necessarily bad, that is, whether it will lead to socially undesirable consequences. The case can be made, I think, that the oversupply could lead to some desirable effects.

We have several recommendations regarding aggregate supply. First of all, we would tentatively recommend that at this time, the Federal Government not attempt to influence physician supply in the aggregate. We believe this should be left up to the marketplace to determine.

Secondly, we believe the Federal Government should concentrate its efforts in dealing with specific problems in the manpower area—for example, the specialty distribution of physicians, the geographic distribution of physicians, minority representation in medicine and the quality of medical care.

Finally, we would recommend that if anybody takes steps to reduce the aggregate supply of physicians that this be done by reducing entering medical school class size, rather than by reducing the number of first-year residency positions in graduate medical education. We think to do the latter could jeopardize the ability of qualified U.S. medical school graduates to complete their training.

Next, I would like to summarize our preliminary conclusions and recommendations regarding the supply of primary care physicians. We have defined primary care as family practice, general internal medicine and general pediatrics. We have concluded that there is an undersupply of certain primary care physicians together with an oversupply in some of the non-primary care specialties.

More specifically, we believe there is an undersupply of physicians in family practice, an impending undersupply of physicians in general internal medicine, and an adequate supply of physicians in pediatrics. I will not take the time today, Mr. Chairman, to detail the data which led to these conclusions, but I would be happy to discuss it during the question period if you wish.

We have developed several preliminary recommendations in the primary care area. First of all we believe that medical school graduates should be encouraged to enter training in primary care, particularly in family practice and general internal medicine; secondly we believe that State and Federal support for primary care educational programs should be continued, including Title VII primary care grants. We think this is essential.

There are a number of other recommendations which are in the written material that I have given you.

Very quickly, let me discuss our recommendations in geriatrics.

We have tentatively recommended that additional emphasis be placed on geriatric training in view of the Nation's aging population. We have not taken a position on whether geriatrics should be a separate specialty. Actually, we would favor multiple pathways to competence in geriatric medicine.

We have also taken note of a number of problems in financing training in geriatrics which are listed in your written material.

I think I'll stop on geriatrics with those comments.

Finally, I would like to comment on the adequacy of residency training positions in the United States. We have not attempted to estimate the precise number of residency training positions that should be available, but we feel very strongly that there should be enough to accommodate those who graduate from medical schools in the United States. There were about 17,400 U.S. medical school graduates last year.

In addition, there should be enough positions, Mr. Chairman, to accommodate graduates of foreign medical schools who are qualified and have the knowledge and skills that enable them to compete with U.S. medical school graduates.

Those would be my comments, Mr. Chairman, and I would be happy to respond to questions.

[The prepared statement of Dr. Vanselow follows:]

STATEMENT BY

NEAL A. VANSELOW, M.D.

CHAIRPERSON

COUNCIL ON GRADUATE MEDICAL EDUCATION

SUBMITTED TO THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

APRIL 28, 1988

Mr. Chairman and Members of the Committee:

I am pleased to have the opportunity to be with you today to discuss the preliminary conclusions and recommendations of the Council on Graduate Medical Education (COGME) regarding certain issues relating to the reauthorization of the health professions authorities in Title VII of the Public Health Service (PHS) Act.

In my statement, I will first provide a brief description of COGME. I will next discuss the preliminary conclusions and recommendations of the Council in four areas. These include: (1) the adequacy of the aggregate supply of physicians; (2) the adequacy of the supply of primary care physicians; (3) developments in geriatrics medical training; and (4) the adequacy of residency training positions.

At the outset, I would like to note that the first report of the Council to the Congress and the Secretary of the Department of Health and Human Services will be submitted by July 1, as mandated by statute. The Council meets next week to finalize its conclusions and recommendations for this report. As such, the testimony provided today should not be viewed as the Council's formal and final position on these issues; rather, it should be viewed as representing the Council's tentative conclusions and recommendations in these four areas.

Brief Description of COGME

The Council on Graduate Medical Education (COGME) was established by Congress on April 6, 1986, with a specified termination date of September 30, 1996. Its first report due by July 1, 1988.

The Council is charged with providing advice to Congress and to the Secretary of Health and Human Services as well as the private sector in three major areas:

1) first, on physician manpower--this includes the supply and distribution of physicians, both in the aggregate and by specialty;

2) secondly, on matters pertaining to foreign medical graduates;

3) and, finally, on issues of undergraduate and graduate medical education. In its first report the Council will concentrate on the financing of graduate medical education.

The Council is composed of 17 members; 14 are private citizens appointed by the Secretary of Health and Human Services to represent physician organizations, student and house officer groups, foreign medical graduates, schools of medicine and osteopathy, teaching hospitals, health insurers, business, and labor. There are also three federal representatives including the Assistant Secretary for Health, the Administrator of the Health Care Financing Administration, and the Chief Medical Director of the Veterans Administration.

The Council is advisory--not regulatory. Since late 1986 it has held five meetings and conducted a two-day public hearing. Because of time and budgetary limitations it has not been able to collect primary data of its own but it has reviewed a great deal of data collected by others and has debated the issues within its charge at great length.

Let me now turn my attention to the four substantive areas related to Title VII that I have been asked to comment upon.

I. Adequacy of the Aggregate Supply of Physicians

Given the assumption that current policies and present trends will continue, the Council has adopted the preliminary conclusion that there now is or soon will be an aggregate oversupply of physicians in the United States. The Council believes, however, that it is impossible to quantify the extent of oversupply with any degree of precision or to predict how far into the future it will persist.

These preliminary conclusions and recommendations have been based on the following: a review of the 1980 report of the Graduate Medical Education National Advisory Committee (GMENAC); a review of the manpower projections of the Bureau of Health Professions of HRSA; an analysis of the use rate of physicians in managed care systems such as HMOs; an analysis of market trends; and testimony at our public hearing. In making its assessment the

Council has been cognizant of the many factors which affect both the supply and the demand sides of the physician manpower equation and of the difficulty in quantitating many of them.

The Council has also noted that available information regarding the consequences of a physician oversupply is not definitive. Both "positive" and "negative" effects can be identified. Desirable consequences may include: an increased availability of physician services; an improved quality of care due to additional time available per patient; and greater physician attention to health promotion and disease prevention activities, teaching, and community service. Undesirable consequences may include: poorer quality of care due to fewer opportunities for maintaining skill levels; added patient risks resulting from any tendency to perform "unnecessary" procedures; and increased expenditures for health care.

Finally, the Council is persuaded that at the present time the federal government should not attempt to influence physician supply in the aggregate. This should be left to the marketplace to determine. Government should instead concentrate its efforts on dealing with certain specific problems in the physician manpower area such as specialty distribution, geographic distribution of physicians, minority representation in medicine, and the quality of medical care.

The Council has also reached the preliminary conclusion that if steps are taken to reduce the physician supply, the reduction should take place in medical school entering class size rather than in the number of residency positions in graduate medical education. We are concerned that reductions in the number of graduate medical education positions could jeopardize the ability of qualified U.S. medical school graduates to complete their medical training. This point will be returned to later in my testimony.

II. Adequacy of the Supply of Primary Care Physicians

The Council has tentatively concluded that there is evidence of an undersupply of certain primary care physicians together with an oversupply in some non-primary care specialties. We have defined primary care physicians as those specializing in family practice, general internal medicine, and general pediatrics. Recent trends indicate that there has been only a modest increase in the number of residents in training in these specialties. If this trend continues, the projected number of physicians in primary care graduate medical education programs will be considerably lower by 1990 than that projected by the Graduate Medical Education National Advisory Committee (GMENAC), which otherwise considered that the number of primary care physicians in 1990 would be adequate relative to the need.

The Council has tentatively concluded that there is an undersupply of physicians in family practice. The demand for family practitioners is increasing but there is evidence that the supply is unable to keep up with this demand. The number of family practice residency programs, which experienced great growth in the years following the inception of the specialty, began to level off in 1983, and the number of residents has leveled off as well. With more than one out of three family physicians/general practitioners aged 55 years and older, attrition from practice for this discipline is expected to be high in the next 10-15 years.

The Council has also tentatively concluded that there is an impending undersupply of physicians in general internal medicine. We have noted with great interest the recent study that Lewin and Associates has conducted for the Federated Council for Internal Medicine. This study indicated that if current trends continue, increasing shortages will result for general internists each year between now and 2020 while most subspecialties of internal medicine will be in surplus.

Finally, the Council has tentatively concluded that there appears to be an adequate supply of physicians in pediatrics at present. Over the past 20 years, the total number of pediatricians has doubled while the age group population served by pediatricians has diminished significantly. The Council recognizes however that the adequacy of pediatric manpower could be significantly affected by changes in national health policy which broaden insurance coverage for children.

The Council's tentative recommendation is that allopathic and osteopathic school graduates should be strongly encouraged to enter training in primary care, particularly in family practice and general internal medicine.

A critical factor in encouraging primary care graduate medical education is adequate financing. The Council believes that the financing of graduate medical education is particularly problematic in primary care, particularly in family medicine. The major sources of financing for family medicine residency programs are physician services to patients, hospital support, and public funds. Each provides about one-third of training program revenues. We believe that neither physician service revenues nor hospital payments are likely to increase significantly. Accordingly, the Council believes that substantial support for family practice programs must continue to come from State and Federal sources, and that government should not reduce its efforts at this time.

More specifically, the Council has tentatively recommended that Federal and State support for primary care programs be continued, including Title VII primary care grants and other support for primary care programs. In addition, organized private sector initiatives to support primary care training should be expanded. The Council also tentatively supports the recommendation of the Physician Payment Review Commission that careers in primary care be made more attractive by exempting primary care services from reductions in Medicare fee increases.

Finally, the Council has noted the increasing importance of training in ambulatory care settings for all specialties but particularly for the primary care disciplines. As inpatient hospital use declines, patients are receiving more and more of their care in the outpatient clinic or in the physician's office. There are difficulties in financing graduate medical education in the ambulatory environment, however, due to lower levels of payment by third parties and the increased logistical problems of teaching in such settings. In addition, the current financing of graduate medical education through Medicare results in disincentives for ambulatory training since payments are made only through hospitals. Current payment methods make it difficult for entities other than those owned and operated by hospitals to secure financing for the additional costs of operating a teaching program in an ambulatory setting over and above resident salaries and fringe benefits. The Council is considering recommendations that would deal with this problem by making it possible for organizations other than hospitals to receive Medicare payments for graduate medical education.

III. Developments in Geriatric Medical Training

The Council has tentatively recommended that additional emphasis be placed on training in geriatrics in view of our nation's aging population. It has not, however, taken a position on whether geriatrics should become a separate specialty of medical practice; rather it has favored multiple pathways to competence in geriatric medicine by providing geriatric training to individuals in a variety of existing specialty disciplines.

Information available to the Council suggests significant problems in the financing of geriatric medical training. Medicare does not appear to be a major source of financing for geriatrics training, even though Medicare pays substantial amounts for graduate medical education. Other problems in financing geriatric medical training include difficulties in supporting training in non-inpatient settings, and the relative lack of reimbursement to physicians for the amount of time spent in providing complex non-procedural services.

The Council believes that allopathic and osteopathic medical school graduates should be encouraged to take training in geriatric medicine. It has also tentatively recommended that Federal and State support for geriatric training be continued.

IV. Adequacy of Residency Positions

The Council has not attempted to estimate the total number of residency positions needed in the United States. Its preliminary recommendation, however, is that if attempts are made to reduce the overall supply of physicians, this should be done by reducing entering class size in the nation's medical schools rather than by reducing the number of first year residency training slots. This implies that there should at least be enough first year residency positions to accommodate qualified graduates of U.S. medical schools which numbered 17,409 (15,830 allopathic and 1,579 osteopathic) in 1987.

In addition there should be enough first year residency positions to accommodate those graduates of foreign medical schools who have the necessary qualifications are are able to compete successfully with graduates of U.S. medical schools for a residency position. In regard to foreign medical graduates, the Council has tentatively recommended against the establishment of policies which would discriminate against medical school graduates on the basis of citizenship, immigration status, or medical school location. Rather, it believes that selection into graduate medical education programs should be based on the relative qualifications of the individual applicants, not on group or institutional associations.

Conclusion

In conclusion let me emphasize again that the finding and recommendations of the Council I have outlined today must be viewed as tentative. We will meet again on May 2nd and 3rd to finalize our first report to Congress and to the Secretary. It is of course possible that some of what I have presented today will be changed at that meeting.

Thank you again for allowing me the opportunity to testify today.

Senator **Matsunaga**. Thank you very much, Dr. Vanselow.

As some of you may have observed, we have a "traffic light" system here, with the green, yellow and red. Of course, when the green is on, that is "go"; when the yellow comes on, that means "go like hell"; and when the red comes on, that means "stop", and then we go into the questioning period. You have kept within your time, according to the lights, and I congratulate you both.

Dr. Vanselow, along with the other members of the Committee on Labor and Human Resources, I look forward to the recommendations from the Council on issues of physician supply and specialty distribution. You indicated in your testimony that the Council will most likely conclude that a surplus of physicians exists. However, published articles indicate that we may be facing a physician shortage instead.

What should we in Congress do in the light of these conflicting assessments?

Dr. **Vanselow**. Well, Mr. Chairman, I am assuming you are referring to the recent articles in the New England Journal of Medicine, which suggest that the physician supply will either be in balance or that there will be a shortage of physicians as years go on.

Senator **Matsunaga**. Yes.

Dr. **Vanselow**. I think that the different views you are getting reflect the extreme difficulty, because of the many variables on both the supply and the demand side of the equation, of predicting with any degree of certainty as to where we stand or where we will be.

You will find that our Council is being much less specific about the supply of physicians than our predecessor, the Graduate Medical Education National Advisory Committee was.

We have concluded, however, looking at essentially the same data that others have, that there still is a surplus. And of course, we would hope that you would accept our recommendation.

Senator **Matsunaga**. What figures do you use—how many people per doctor? Do you use such figures?

Dr. **Vanselow**. No. We have not used figures of that type, Senator.

Senator **Matsunaga**. I would be interested to see your report. I would like to know how you calculate whether there is a surplus or a shortage of physicians.

Dr. **Vanselow**. Senator, the things we have looked at and reviewed are the so-called GMENAC report, published in 1981. We have looked at data gathered by the Bureau of Health Professions. That is an ongoing study which is reported every two years, which measures supply of physicians against demand for physicians and does look at data such as how many physicians there are per unit of population.

We have looked at the use of physicians in managed care settings such as HMOs; we have looked at market indicators such as physician incomes, number of patients seen by each physician, and we have received a great deal of testimony at the public hearing.

Senator **Matsunaga**. You included in your testimony the belief that we have too few family physicians and general internists. S. 2229 maintains support for family medicine and general internal medicine residency programs. What other means would you suggest to increase the number of medical students who are interested in pursuing primary care specialties?

Dr. **Vanselow**. There are a number of factors, Senator, that we think are very important. For example, we believe that when you are accepting students to medical school, it would be a good policy to attempt to select students who have a high likelihood of going into family practice.

As you know, I am from the University of Minnesota, and we have a medical school at Duluth, which is a two-year school, that has been very successful in terms of selection criteria in picking students who end up in family practice.

We also believe that students should be exposed to family practice and primary care disciplines at the early stage of their career, and this can be done by preceptorships with primary care physicians.

We also think that there is a problem on the other end of the spectrum, that is, the reimbursement paid to physicians because primary care specialties are cognitive disciplines. They are not now reimbursed as well as some of the procedurally-oriented disciplines. We think that primary care disciplines should be exempted from the decreases in fee increases that are paid to physicians through Medicare; in other words, that there ought to be better reimbursement for primary care.

Senator **Matsunaga**. Dr. Vanselow, one area in which you argue that the Federal Government should concentrate resources is in increasing minority representation in the health professions. Are the current programs effective, and if not, how could they be improved?

Dr. **Vanselow**. Well, Mr. Chairman, I would have to agree with Dr. Sundwall that current programs have had some effect but we do not have the minority representation in medicine yet that all of us would like to see.

I should note that the Council has not adopted final recommendations in this area yet; this is so important that we have appointed a special subcommittee to study it, and that subcommittee will be coming forward with recommendations early next week. We believe, however, that one of the big problems is medical school debt and that steps taken to reduce that debt, the debt that graduates have before they enter training, would be very important.

Senator **Matsunaga**. Thank you very much, Dr. Vanselow, Dr. Sundwall, Dr. Clinton and Mr. Schwab. We appreciate your coming before the Committee.

There is a vote now on the Floor of the Senate, and I will have to go and vote. We do not have anyone to take over, so I will declare a short recess until such time as I have voted and returned. Then we will call the next panel of witnesses.

The Committee stands in recess subject to the call of the Chair.

[Short recess.]

Senator **Matsunaga**. The Committee will come to order.

Our next panel of witnesses consists of Patrick Duarte, President and Chief Executive Officer, Rehabilitation Hospital of the Pacific, from Honolulu, Hawaii. He comes from a paradise where everybody would like to go, and I wish they would go, with plenty of spending money, that is.

We also welcome Polly Fitz, who is a Professor, School of Allied Health Professions, University of Connecticut, in Storrs, Connecticut.

We would be happy to hear from you first, Patrick.

STATEMENTS OF PATRICK DUARTE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, REHABILITATION HOSPITAL OF THE PACIFIC, HONOLULU, HI, ACCOMPANIED BY SUSAN SCOTT, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION; AND POLLY FITZ, PROFESSOR, SCHOOL OF ALLIED HEALTH PROFESSIONS, UNIVERSITY OF CONNECTICUT, STORRS, CT

Mr. DUARTE. Senator Matsunaga, aloha.

Senator MATSUNAGA. Aloha.

Mr. DUARTE. Thank you for inviting me to present testimony on the shortage of medical rehabilitation personnel.

As mentioned, my name is Patrick Duarte, and I am with the Rehab Hospital of the Pacific, and we are a 100-bed comprehensive medical rehabilitation facility in Honolulu.

I am also a member of the Board of Directors of the National Association of Rehabilitation Facilities and a member of the Governing Council of the American Hospital Association's Section for Rehabilitation Hospitals and Programs.

With me today is Susan Scott, of the American Occupational Therapy Association.

I would like to submit written testimony for the record, and I will highlight for the Committee several salient points from that statement.

Senator MATSUNAGA. Your statement will appear in the record as though presented in full.

Mr. DUARTE. Thank you.

Over the last several years, medical rehabilitation facilities have experienced a marked growth in the number of patients referred for services. More people have been able to survive devastating illnesses and accidents due to recent medical and technological advances.

The elderly population, often victims of stroke, arthritis and hip fractures, all of which require medical rehabilitation treatment, is expanding and will continue to expand in the future.

Furthermore, there is a growing awareness of the benefits of comprehensive medical rehabilitation. These factors have significantly increased the need for rehabilitation services and, along with it, the demand for rehabilitation professionals.

The supply of medical rehabilitation professionals, particularly in the areas of occupational therapy, physical therapy, speech language pathology and audiology, has not been able to meet today's demand for their services. Rehabilitation hospitals throughout the country are reporting acute shortages of professionals. School systems, home health agencies, long-term care facilities, and medical clinics are likewise finding it extremely difficult to fill their vacancies.

Educational programs for training rehabilitation professionals have not been able to keep up with the current demands, nor do they have the capacity to meet future needs. This is due to lack of funding for program development and expansion, inadequate supply of faculty, and little or no funds for scholarships or loans to attract students into the programs.

What can be done to help remedy this situation?

Title VII of the Public Health Service Act historically has provided funds for education of health professionals, including allied health professionals such as those described above. However, allied health has not had any funding since 1980.

Given the extreme shortages, we recommend that in reauthorizing Title VII of the Public Health Service Act, Congress authorize $20 million to provide: 1) grants for programs for the training of rehabilitation professionals; 2) grants to public and nonprofit educational entities to support the graduate educational programs in physical therapy, occupational therapy, speech and language pathology and audiology; and 3) grants or contracts with schools of occupational therapy, physical therapy, speech and language pathology and audiology to provide financial assistance to students enrolled in these programs.

Senate Bill 2229 represents a major step toward addressing a severe problem, and we commend you for considering this bill. We welcome the much-needed additions of funding for allied health students in the areas of program development, assistance to doctoral students, and direct assistance to entry-level students in rehabilitation professions.

We also welcome the addition of allied health to the Health Education Assistance Loan Program and the Health Professions Student Loan Program. These programs are extremely important to rehab professionals. We strongly support these provisions in Senate Bill 2229, and we urge the Committee to support them as well.

Before I close, I would like to personally express my appreciation and that of Dr. Satoru Izutsu of the University of Hawaii for the clinical psychology provisions in Senate Bill 2229.

Thank you very much for the opportunity to testify. I would be glad to answer any questions you may have.

[The prepared statement of Mr. Duarte follows:]

STATEMENT OF THE

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
AMERICAN PHYSICAL THERAPY ASSOCIATION
AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION
NATIONAL EASTER SEAL SOCIETY
NATIONAL ASSOCIATION OF REHABILITATION FACILITIES
AMERICAN HOSPITAL ASSOCIATION

ON

REAUTHORIZATION OF TITLE VII OF THE PUBLIC HEALTH SERVICE ACT
REGARDING ALLIED HEALTH PERSONNEL
S.2229, THE HEALTH PROFESSIONS REAUTHORIZATION ACT

PRESENTED BY:

PATRICK J. DUARTE
PRESIDENT AND CHIEF EXECUTIVE OFFICER
REHABILITATION HOSPITAL OF THE PACIFIC
HONOLULU, HAWAII

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SUBMITTED FOR THE RECORD OF THE HEARING HELD ON

APRIL 28, 1988

BY THE

LABOR AND HUMAN RESOURCES COMMITTEE

U.S. SENATE

STATEMENT OF THE

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
AMERICAN PHYSICAL THERAPY ASSOCIATION
AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION
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AMERICAN HOSPITAL ASSOCIATION

ON

REAUTHORIZATION OF TITLE VII OF THE PUBLIC HEALTH SERVICE ACT REGARDING ALLIED HEALTH PERSONNEL
S. 2229, THE HEALTH PROFESSIONS REAUTHORIZATION ACT

Dear Mr. Chairman:

Good afternoon. Thank you for inviting me to present testimony on the shortage of medical rehabilitation personnel as your Committee considers S.2229, a bill to reauthorize Title VII of the Public Health Service Act. My name is Patrick J. Duarte. I am the President and Chief Executive Officer of the Rehabilitation Hospital of the Pacific, Honolulu, Hawaii, and a member of the Board of Directors of the National Association of Rehabilitation Facilities (NARF) and the Governing Council of the American Hospital Association Section for Rehabilitation Hospitals and Programs. My facility is a one hundred bed freestanding comprehensive rehabilitation hospital. I would like to submit this written statement for the record on behalf of the American Occupational Therapy Association, the American Physical Therapy Association, the American Speech-Language-Hearing Association, the National Easter Seal Society, the National Association of Rehabilitation Facilities, and the American Hospital Association.

The American Occupational Therapy Association is the national professional organization for occupational therapists and occupational therapy assistants. The American Physical Therapy Association is the national professional organization for physical therapists and physical therapist assistants. The American-Speech-Language-Hearing Association is the national professional organization representing speech-language pathologists and audiologists. The National Easter Seal Society is a national organization of providers of rehabilitation and other health services to persons with disabilities. The National Association of Rehabilitation Facilities is the national voluntary membership organization of community-based medical, vocational and comprehensive rehabilitation facilities. The American Hospital Association is a national organization of health care institutions including rehabilitation hospitals and units.

I. BACKGROUND

Over the last few years, medical rehabilitation facilities have experienced a marked growth in the numbers of patients referred for services. More patients are being discharged from acute care hospitals to rehabilitation sooner and sicker. More people are able to survive devastating illnesses and accidents due to recent medical and technological advances. The elderly population, often victims of stroke, arthritis, hip fractures, all of which require medical rehabilitation treatment, is expanding. All of these factors, along with various economic pressures, have acted in concert to put a tremendous strain on our medical rehabilitation facilities, primarily because there are not enough rehabilitation professionals available to treat these patients.

Furthermore, rehabilitation facilities, particularly medical rehabilitation facilities, have been experiencing problems in recruiting and retaining qualified rehabilitation professionals to treat patients. The primary areas of concern are with the numbers of physical therapists and occupational therapists. The most severe shortages, according to NARF members, are of occupational therapists and physical therapists. The need for these professionals far exceeds the supply in all but a few places in the country. This shortage will become more severe in the future as the numbers of elderly (over 65) and frail elderly (over 85) increase, and advances in technology save and prolong life, unless something is done to reverse the trend and increase the number of these therapists in the workforce.

Anecdotal reports show that rehabilitation facilities will recruit directly from other facilities, home health agencies or private practices in their communities by paying considerably higher fees and finder's bonuses, at a minimum. In one instance, a hospital recruited two recently graduated physical therapists from a facility only several miles away for $50,000 in annual salary each. The original facility simply could not meet this salary, although it had paid all costs for initially recruiting the therapists and, in one instance, the undergraduate educational expenses. Other facilities are resorting to bonuses, career ladder opportunities, flexible schedules and hours, paying child care expenses, continuing education, and other strategies to retain hard won therapists. Two new companies were created over the last two years solely to help recruit qualified therapists from abroad. However, even these innovative measures have not alleviated the shortages.

Simply put, the educational programs for rehabilitation professionals cannot meet the current demands or increase the numbers of graduates to meet future needs. This is due to lack of funding for program development or expansion, inadequate supply of faculty and little or no funds for scholarships or loans to attract students into the programs. To help remedy the shortage situation, the above-noted organizations representing therapists and facilities recommend as part of the reauthorization of Title VII, the Public Health Service Act, that Congress authorize a grant program to fund the expansion or development of new programs, increase the number of qualified faculty and attract students into these critical rehabilitation fields.

As you noted, Mr. Chairman, when you introduced S.2229, the Health Professions Reauthorization Act of 1988,

> "The Nation is entering what may be the most severe shortage of allied health professionals ever. The demand for physical therapists, occupational therapists, and other practitioners in the rehabilitation fields has hit crisis proportions among hospitals, nursing homes, home health agencies and hospices. These therapists are essential in the provision of care to the elder-

> ly, the chronically ill, handicapped children, and the mentally retarded. Shortages in these fields are expected to intensify in the coming years. This growing problem requires a renewed Federal initiative to assure that an adequate number of these practitioners is available."

Mr. Chairman, the above-noted organizations commend you for introducing S.2229 to reauthorize Title VII of the Public Health Service Act. We welcome the much needed addition of funding for allied health students in the areas of program development, assistance to doctoral students and direct assistance to entry level students in rehabilitation professions, especially since allied health has not had any funding since 1980. We also welcome the addition of allied health to the Health Education Assistance Loan (HEAL) Program and Health Professions Student Loan Program. We strongly support these provisions in S.2229 and urge the Committee to support them.

Because of the severe shortage of occupational therapy, physical therapy and speech-language pathology and audiology personnel, our organizations further recommend that additional monies be set aside for occupational therapy, physical therapy and speech-language pathology and audiology either through bill language or strong Committee report language designating funding specifically for these two disciplines.

II. MEDICAL REHABILITATION PERSONNEL: SHORTAGE AND DEMAND

A. Occupational Therapy

1. Nature of the Profession

Occupational therapy is a health and rehabilitation profession that provides services to individuals who are physically, psychologically, or developmentally disabled, including those suffering from strokes, heart disease, arthritis, diabetes, serious burns, spinal cord injuries, and psychiatric disorders. The profession tailors the rehabilitation process individually for each patient and, through evaluation and treatment, seeks to achieve restoration or improvement of impaired functions. The goal of occupational therapy is to assist patients in achieving a maximum level of independent living by developing the capacities that remain after disease, accident, or deformity. Occupational therapists in mental health settings treat individuals who may be mentally ill, mentally retarded, or emotionally disturbed. Among the emotional disorders that occupational therapists encounter are alcoholism, drug abuse, depression, eating disorders, and stress-related disorders. The occupational therapist's goal is to provide the patient with the functional as well as cognitive, social, and organizational skills necessary to function in the community.

Preparation for this field requires a bachelor's degree in occupational therapy. Thirty six states, Puerto Rico, and the District of Columbia require a license to practice. Applicants for a license must have a degree or certificate from an accredited educational program and pass a national certification examination. Certification is available through the American Occupational Therapy Certification Board (AOTCB) which awards the title of registered occupational therapist (OTR) to qualified applicants. Occupational therapy assistants are trained in two year community college programs. Upon successful completion of the national certification examination they can be certified by the AOTCB which awards the title of certified occupational therapy assistants (COTA) to qualified applicants.

2. **Shortage of Occupational Therapy Personnel**

   o The New York State Health Department assembled a Task Force on Health Personnel in April 1987. According to the Task Force survey, occupational therapy has the highest percentage rate of vacancies among allied health care professions. That figure is currently at 18 percent in hospital settings and 12.7 percent in nursing homes.

   o Hospitals, skilled nursing facilities, home health agencies, rehabilitation facilities, and public school systems continue to have difficulty in meeting the demand for occupational therapy personnel.

   o The American Hospital Association (AHA) (1982-84 survey) has found that occupational therapy position vacancy rates are one of the three highest among the health professions in facilities surveyed.

   o Studies indicate that while 35% of all nursing home patients require occupational therapy services, only 10% are actually receiving them due to manpower constraints.

- A survey of rehabilitation service providers funded by the Rehabilitation Services Administration (RSA) ranked occupational therapy practitioners second in terms of inadequate supply of rehabilitation personnel.
- A U.S. Department of Education study on implementation of the Education of the Handicapped Act (P.L. 94-142) indicates a 20% shortfall in occupational therapy practitioners available to work in the public school systems.
- The American Medical Association's Council on Allied Health Education and Accreditation (CAHEA) reports that 89 percent of program directors surveyed considered occupational therapy to be under-supplied.
- Private-sector manpower assessments conservatively estimate the current nationwide shortage in occupational therapy personnel to be at least 30 percent.

3. Demand

- The U.S. Department of Labor's Bureau of Labor Statistics (BLS) projects a 52% increase in demand for occupational therapists between 1986-2000.
- The U.S. Department of Health and Human Services, Health Resources and Services Administration, reports that "Demand for occupational therapists is expected to remain high...due to increases in the need for such services by an aging population..."
- Recent legislative action by the Congress to expand services under the Education of the Handicapped Act and the Medicare

program will significantly increase demand for occupational therapy personnel.

- The occupational therapy educational system has stopped growing. Despite private-sector promotional efforts, limited faculty resources and increases in the cost of education have resulted in the number of graduates from accredited schools remaining static since 1977.

B. Physical Therapy

1. Nature of the Profession

Physical therapy means the examination, treatment, and instruction of human beings to detect, assess, prevent, correct, alleviate and limit physical disability, movement dysfunction, bodily malfunction, and pain from injury, disease and any other bodily and mental conditions, and includes the administration, interpretation, and evaluation of tests and measurements of bodily functions and structures; the planning, administration, evaluation, and modification of treatment and instruction, including the use of physical measures, activities, and devices for preventive and therapeutic purposes; and the provision of consultative, educational, and other advisory services for the purpose of reducing the incidence and severity of physical disability, movement dysfunction, bodily malfunction and pain. Patients treated by physical therapists include accident victims, handicapped children, and stroke victims. Physical therapy also is used in the treatment of multiple sclerosis, cerebral palsy, nerve injuries, amputations, fractures, arthritis, heart disease, and other conditions.

All states, the District of Columbia, and the Commonwealth of Puerto Rico require a license to practice physical therapy. Applicants must have a degree or certificate from an accredited physical therapy educational program prior to taking the licensure examination.

2. Shortage of Physical Therapy Personnel

- There are an estimated 65,000 licensed physical therapists in the United States today. Of this population, 70% (45,500) work full-time, 23% (14,950) work part-time and 7% (4,550) are not working or are retired. Thus, the current work force is estimated to be 60,450.
- The latest Bureau of Labor Statistics, based on 1986 information, indicates that there are 61,000 physical therapist jobs in the United States; therefore, the current overall demand exceeds supply by over 500 physical therapists.
- The Bureau of Labor Statistics also estimates the growth in jobs by the year 2,000 to be at 87% (53,000 or approximately 3,800 new jobs per year). This latter figure represents the demand side of the equation and is important to bear in mind in light of the supply information that follows.
- There are approximately 3,900 new licensees entering the physical therapy workforce per year. By the same token, there is an estimated 2.4% attrition rate from the annual work force, which represents an annual loss of about 1,451 physical therapists. This results in a net annual gain in the total work force of 2,449 physical therapists.

3. Demand

- Calculating the difference between the annual growth in physical therapist jobs and the growth of the numbers of physical therapists available, our best estimates are that there will be an annual deficit in the supply/demand equation of approximately 1,351 physical therapists.
- Additionally, this gap is expected to increase in the coming years unless efforts are made to sufficiently increase the supply to meet the growing demand.
- The practice settings experiencing the greatest shortages are hospitals, schools, nursing homes and rehabilitation centers.
- Physical therapy education is experiencing a short fall in qualified faculty. An American Physical Therapy Association (APTA) Task Force predicted that 300 doctorally prepared faculty will be needed to teach in physical therapy entry-level education programs by 1997. This number accounts for no increase either in the number of programs or in the number of students enrolled. Consequently, the number of faculty must be increased to meet the increase in class sizes necessary to graduate the additional therapists to meet the demand.
- A 1988 APTA study indicates that there are 100 faculty vacancies in education programs for the physical therapist.
- A recent survey funded by the Rehabilitation Services Administration ranked the shortage of physical therapists first among rehabilitation personnel.
- Research conducted by the APTA has shown that the application to acceptance ratio in physical therapy entry level education

programs is nearly 5:1. Thus, a large number of qualified students are adversely affected by a lack of funding. If funds were available to increase enrollment class sizes, greater numbers of physical therapists would be graduated to meet the demand.

- The 1987 New York State Health Department Task Force estimated a physical therapy vacancy rate of 15% in hospitals.

C. Speech-Language Pathology and Audiology

1. Nature of the Profession

Speech-language pathologists and audiologists are health, rehabilitation and education professionals who provide services to people in all age groups who have communication disorders. Speech-language pathologists are specialists in the understanding and expression of human communication and its normal development, and in its disorders and the prevention of disorders such as articulation, voice, fluency, auditory and/or visual processing and memory, and interactive communications. They determine the need for augmentative communication devices and provide individuals with training in the use of such devices. Audiologists are specialists in the prevention, identification and assessment of hearing impairments, and in the habilitation and rehabilitation of persons with hearing impairments, including the fitting and dispensing of hearing aids.

Speech-language pathologists and audiologists provide services to individuals with communication disorders resulting from congenital disorders (such as deafness in children), stroke (resulting in aphasia), learning disabilities, head injury, and noise-induced hearing loss. Individuals with developmental disabilities and mental retardation may have related communication disorders and can benefit from rehabilitative services provided by speech-language pathologists and audiologists.

The American Speech-Language-Hearing Association (ASHA) awards the Certificate of Clinical Competence (CCC) to individuals with a master's degree who have completed a year of supervised clinical training and passed a national examination. Thirty-seven states have licensure laws in speech-language pathology and audiology and the requirements are generally similar to the CCC. There are over 240 graduate training programs in the field, the majority of which are accredited by the Educational Standards Board (ESB) of ASHA. The ESB sets the national standards for graduate education that are recognized by the U.S. Department of Education.

An estimated 24 million people in the United States suffer from hearing, speech or language disorders. The prevalence of hearing loss, according to the Health Interview Survey (1982) has been estimated to be 8.7% of the non-institutionalized population or 19.7 million Americans. Hearing loss is most common among the elderly, with one out of every four people over the age of 65 suffering from a hearing disorder. Speech and language impairments are most common among children and make up the second largest category of disabilities in the public schools. For the rest of this century and beyond, the numbers of persons with communication disorders will increase at faster rates than the total population.

2. **Shortage of Speech-Language Pathologists and Audiologists**
   - o A majority of nursing homes neither employ a speech-language pathologist and audiologist nor provide speech-language-hearing services, despite a reportedly high prevalence of communication disorders among their residents.
   - o An American Hospital Association survey (1982-84) showed that speech-language pathologists and audiologists ranked 7.5 (tied with occupational therapy assistants) in vacancy rates among 34 professions.
   - o The Bureau of Health Professions reports that over two-thirds of all counties in the United States may have no available audiological services.
   - o There has been a serious decline in graduate program faculty in communication sciences and disorders. During the five-year period between 1982 and 1987, a loss of 215 full-time faculty positions (nearly 10%) has occurred.
   - o Minority representation in the profession is only about 4% and there was a disturbing decline in minority student enrollment in the early 1980s. Reductions in federal financial assistance appear to have been a leading cause of this trend.

3. **Demand**
   - o A recent study by the University of Georgia Institute of

Higher Education found that 73% more hospital based speech-language pathologist positions will be needed by 1995, the highest among any health care profession in the State of Georgia.

- A new report, Personnel for Health Needs of the Elderly Through the Year 2020, by HHS, projects a dramatic increase in elderly persons with communication impairments. The report estimates that 17,700 full-time audiologists will be needed 30 years from now to serve elderly individuals with hearing loss -- more than double the current supply of audiologists. A huge increase in the number of speech-language pathologists needed to serve the elderly -- almost 24,000 by the year 2020 -- is also projected.
- The percentages of speech and hearing impaired persons aged 65 and over were 20% and 43% respectively in 1980, but will grow to 25% and 46% by the year 2000 and to 39% and 59% by the year 2050. As the communicatively handicapped population increases, so will the demand for qualified speech-language pathologists and audiologists to provide health care and rehabilitative services.
- As a result of the new requirements in P.L. 99-457 for services to infants, toddlers and preschool children with disabilities, many more qualified speech-language pathologists and audiologists will be needed to serve these age groups. Among 3 to 5-year-old children with disabilities, the vast majority (70.5% in the 1984-85 school year) had a primary handicap of speech or language impairment. This does

not include the large number of children with other primary handicaps, such as mental retardation and cerebral palsy, who have concomitant speech or language disorders. All of these children require the services of qualified speech-language pathologists.

- From a need perspective, it is clear that more qualified professionals are needed to serve the estimated 24 million people in the United States who have speech, language or hearing impairments. With a workforce of approximately 86,000, the ratio of personnel-to-communicatively impaired population is 1:280, an imbalance which demonstrates that many additional speech-language pathologists and audiologists need to be trained to serve this large and growing population.

III. CONCLUSION AND RECOMMENDATIONS

The educational system for rehabilitation professions has not been able to meet the demand for these core professionals. This inability to produce enough therapists is caused by:

- Inability to increase class sizes for lack of funds, particularly in physical therapy;
- Inadequate number of educators in these professions;
- Shortage of programs nationwide in certain professions, such as occupational therapy; and
- Decreasing funds for scholarships and loans to attract students into these programs.

Title VII of the Public Health Service Act historically has provided funds for education of health professionals, including allied health professionals such as those described above. Given the extreme shortages of occupational therapists and physical therapists, we recommend that in reauthorizing Title VII of the Public Health Service Act, Congress authorize $20 million to provide:

A. Grants for programs for the training of rehabilitation professionals. These grants would be for planning, development, operation or maintenance of the programs.

B. Grants to public or nonprofit educational entities to support the graduate educational programs in physical therapy, occupational therapy, speech-language pathology and audiology.

C. Grants or contracts with schools or programs of occupational therapy, physical therapy, speech-language pathology and audiology to provide financial assistance to students enrolled in these programs.

Mr. Chairman, S.2229 represents a large step down this road.

Senator MATSUNAGA. Thank you very much, Mr. Duarte. When you go back, would you extend my best to Satoru?

Mr. DUARTE. Yes, I will.

Senator MATSUNAGA. I want to thank you for that clear description of the shortage of personnel among many allied health disciplines. Do you consider counting the number of vacant positions the best way to determine the demand for allied health professionals?

Mr. DUARTE. Well, I think it is one way to look at the current need for allied health professionals, but I think there are other ways to look at the ongoing demand, including the number of professionals that are being turned out by the schools and comparing that to the need based on the growth rate of the population, especially the growth rate of the elderly, where a lot of the rehabilitation services are consumed.

Senator MATSUNAGA. What kinds of additional data, in your opinion, are needed to accurately determine the demand for allied health professionals?

Mr. DUARTE. I think most of the data that is needed is right now available. Susan might want to comment on that.

Ms. SCOTT. Yes, Senator, we do feel that there is a great deal of data out there on the supply and the demand of these professionals, from the Federal Government, the Bureau of Labor Statistics, the Bureau of Health Professions, from the professional associations that represent these professionals, and from the facilities who utilize these professionals.

Senator MATSUNAGA. How has the Rehabilitation Hospital of the Pacific been affected by the shortage of allied health professionals, and what is the situation for other health care facilities in Hawaii?

Mr. DUARTE. In Hawaii, we are experiencing the same shortage that all hospitals are facing throughout the country, and that is, in looking ahead, our facility projects a need for about, I would say, 10 to 15 rehabilitation professionals within the next six to nine months. And it has been very difficult to find professionals to fill these vacancies.

Other acute care hospitals in Hawaii are looking for physical therapists. The school system is looking for physical therapists, occupational therapists, and speech pathologists. We are looking for all three as well.

Senator MATSUNAGA. Is it because of lack of trained personnel, or is it because of the low salaries offered? Which is it?

Mr. DUARTE. I think it is because of the lack of trained personnel. There are just insufficient numbers to go around.

Senator MATSUNAGA. Thank you.

Now we will be happy to hear from you, Ms. Fitz.

Ms. FITZ. Thank you, Mr. Chairman.

I am Polly Fitz, past President of the American Society of Allied Health Professions, and have just completed my term as a member of the National Advisory Council on Health Professions Education.

Currently, I am a member of the Study Committee for the 1985 Congressionally-mandated study on allied health conducted by the Institute of Medicine.

I choose to highlight my comments rather than read them in their entirety, since I know they will be a matter of record.

Senator MATSUNAGA. Your entire statement will appear in the record as though presented in full.

Ms. FITZ. Thank you.

On behalf of the American Society of Allied Health Professions, I am pleased to submit our comments for the record on the need of the allied health professions in relation to the reauthorization of the Health Professions Education Assistance Act, Title VII of the Public Health Service Act.

The American Society of Allied Health Professions is a national nonprofit scientific and professional organization. It has 1,000 individual members. It serves 20 professional organizations and reflects graduating classes of approximately 40,000 professionals each year.

The population which the Society serves is a cadre of professionals, titled "allied health." And for me to describe in five minutes all of the diversity reflected in allied health would be foolhardy, but I would just highlight that I cannot imagine a health care system without the rehabilitative services that were just aptly described by my colleague Mr. Duarte or a health care system without laboratory tests or without radiology services or without emergency services which our communities so count on; without a medical records system that both charts our history and as well helps us audit the quality; no nutrition services for critically ill or chronically ill persons; no dental services in the nature of dental hygienist activities to promote oral health of children as well as older persons. The impact of allied health personnel on the system is far-reaching and is woven into all of the fabric of health care.

I would highlight that the American Society of Allied Health Professions joins in its concern about avoiding the crisis in allied health manpower, and I bring further articles, which I hope can be entered into the record, that document local situations around that shortage.

Other shortages which I would mention specifically in addition to those already presented in the rehab services would be nutrition services, medical records services, all of which a lack of would really present severe shortages for the clients in our system. Our increasing aging population and all of the new treatment facilities really demand new and comprehensive services.

We commend you on the introduction of the bold new Federal initiative in the area of allied health professions, part of Senate Bill 2229. While our counterparts discuss only one profession, we must address a diversity of professions, as I have indicated.

I think that is one of our strengths, because we offer you an integrated approach to the diversity in solving health problems both in our educational institutions and in our practice settings.

Section 403 would offer our educational institutions—and already we have had a comment on the lack of trained graduates—Section 403 would provide new opportunities for curriculum development, interdisciplinary programs and demonstration projects. It would also serve to address the issue of the recruitment of individuals into the allied health professions, especially the under-represented, the minorities.

The National Society of Allied Health Professions has emphasized that there continues to be a consistent decline in the number of black students who enter allied health education programs.

So we therefore commend the Federal initiatives in Senate 2229, Section 403, which speaks to career development and recruitment activities.

It is my belief that we will have to work harder in recruitment to even maintain the numbers we have currently in the system.

I would also note our support for Section 305, which specifically is educational assistance to individuals from disadvantaged backgrounds. I would note that many of our allied health profession programs are in community colleges, close to the communities where many disadvantaged students reside, and are very often the best programs to respond immediately to the needs of both the community, the students, as well as the employers.

I would also re-emphasize the need for traineeships in Section 405 for the advanced training of allied health personnel, specifically highlighting the faculty shortages in occupational therapy and physical therapy.

My last comment would relate to the need, as reflected in Section 406, for more data on the allied health professions. The Institute of Medicine study was hampered by the lack of a primary data system, and I would join my colleagues in supporting synthesis and coalitions in terms of collection of that data.

So in conclusion, we highly commend the sponsors of Senate 2229 for proposing this among the other initiatives. I will close my comments at that point and be glad to answer questions.

[The prepared statement of Ms. Fitz, with attachments, follows:]

ASAHP

TESTIMONY

OF THE

AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

ON THE

HEALTH PROFESSIONS REAUTHORIZATION ACT OF 1988

TITLE VII OF THE PUBLIC HEALTH SERVICE ACT

SUBMITTED TO THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

APRIL 28, 1988

THE AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS
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Mr. Chairman, I am Polly Fitz, Past President of the American Society of Allied Health Professions and have just completed a term as a member of the National Council on Health Professions Education. Currently, I am a member of the Study Committee for the 1985 Congressionally-mandated Study on Allied Health conducted by the Institute of Medicine, Professor at the University of Connecticut in the School of Allied Health Professions, and Associate Director of Travelers Center on Aging in Connecticut. I served ten years as Dean of the School of Allied Health Professions at the University of Connecticut. My health care background is in dietetics and nutrition.

On behalf of the American Society of Allied Health Professions (ASAHP), I am most pleased to submit our comments for the record on the needs of the allied health professions in relation to the reauthorization of the Health Professions Educational Assistance Act, Title VII of the Public Health Service Act.

The American Society of Allied Health Professions (ASAHP) is a national nonprofit scientific and professional organization serving the needs of allied health educators, practitioners, professional institutions and organizations, and others whose mission is to improve health care by enhancing the effectiveness of education for allied health professionals. ASAHP has as its ultimate goal the best possible training and utilization of all allied health professionals. As a means to that goal, the Society provides a vital forum in which allied health administrators, educators and practitioners--their educational and clinical institutions and their professional associations--can address and act on mutual concerns.

Along with over 1,000 individual members, the Society serves and represents a constituency of 20 professional organizations (whose members total approximately 350,000 professionals in related services),* and 120 collegiate schools of Allied Health, containing close to 1,500 allied health educational programs and graduating approximately 40,000 professionals each year. (Graduates of the allied health sciences account for as many as 1 out of every 6 graduated from higher education institutions listed by the U.S. Department of Education).

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*A list of ASAHP member associations is attached.

The population which the Society serves is a cadre of professionals whose expertise spans every facet of the health care system. Over three million health care professionals comprise the allied health workforce (64% or six out of every ten health care workers), providing services in all health care settings (e.g. hospitals, clinics, hospices, extended care facilities, community programs, and schools). Allied health professionals share responsibility for the delivery of health care services, including: services related to the identification, evaluation, and prevention of diseases and disorders, dietary and nutrition services; health promotion services, rehabilitation services, and health systems management services.

From autonomous services of therapists and counselors to supportive skills of health care assistants, the allied health professions include a wide range of disciplines such as audiology, dental hygiene, dietetics, EKG/EEG technology, medical records administration, medical technology, microbiology technology, nutrition, occupational therapy, physical therapy, radiologic technology, respiratory care, speech-language pathology, surgical technology, and others.

THE CRISIS IN ALLIED HEALTH MANPOWER

The current service delivery context for the allied health professions is in an unprecedented state of flux. Not only are there severe shortages in allied health workforce, but also clear evidence of a seriously shrinking applicant pool. The first page of a November 1987 issue of *American Medical News* identifies the shortages in allied health as a "manpower crisis," noting the growing labor shortage in all areas of allied health is "crippling hospitals across the nation."

Projections indicate that "between the years 2020 and 2030, 75 percent of health providers' time may be spent providing services to the elderly . . . .Over 65 percent of allied health professionals will be employed outside the hospital, in home- and community-based settings where older patients predominate." So stated the American Society for Allied Health Professions' (ASAHP) National Task Force on Gerontology and Geriatric Care Education in its recently-released report, "An Aging Society: Implications for Health Care Needs--Impact on Allied Health Practice and Education."

As evidenced in reports of the American Medical Association, the American Hospital Association, the American Society of Allied Health Professions, the Veterans Administration, the Institute on Aging, the Institute of Medicine, and the Department of Health & Human Services and in presentations to the National Council on Health Professions Education, the shortage of qualified allied health personnel (as in nursing) is well upon us, and it is clear that by the year 2000 there will be an even greater demand for allied health professionals.

Shortages for occupational and physical therapists, and speech, language pathologists and audiologists have been identified as even more severe than those in nursing. According to the latest information from the U.S. Bureau of Labor Statistics, the demand for physical therapists and radiological technologists is projected to rise 87 percent and 65 percent respectively from 1986 to 2000. The demand for occupational therapists will grow 52 percent, for physical therapy aides 82 percent, and laboratory technologists 24 percent, all by the year 2000.

According to the January/February 1988 issue of the Allied Health Education Newsletter, published by the American Medical Association:

> New York State is reportedly facing major shortages in a number of areas, including occupations that work with blood, home health care workers, rehabilitation therapists, physican assistants, and nurses. Massachusetts and other Northeast hospitals add insufficient numbers of respiratory therapists and radiologic technologists to the list. The Greater Cincinnati Hospital Council has asked its 28 members to be supportive of educational programs.

Other areas where severe shortages will be evidenced are in dietetics, dental hygiene, and medical records administration. Such shortages will surely impact the provision of quality care to all Americans, with improved access to quality services standing out as a major unmet health need of our aging society.

The causes of these shortages are multiple and complex. New service delivery settings, (e.g., long-term care, home care), reimbursement policies, demographic changes, and economic pressures are having negative effects on future growth rates for the professions that comprise this workforce. Primarily, the shortages are a result of societal forces and such changes as:

- An increasing aging population;
- An AIDS epidemic with 50,000 infected and hundreds of thousands with HIV at risk in the future;
- Technological advances impacting on the practices and procedures used by allied health personnel;
- New outpatient treatment facilities impacting the environment and structure in which these practitioners work;
- Fewer women entering the allied health professions because of increased career opportunities with higher salaries;
- Severe faculty shortages in key disciplines such as physical therapy and occupational therapy, caused by better economic conditions outside academia; and

- Little or no federal attention or financial support for the education of allied health professionals since 1980.

The uncertainty over future employer and student demand makes any serious planning effort extremely difficult. Planning, in effect, is occuring in a vacuum. Currently, an imbalance exists in the supply-demand situation for the professions as a whole--with demand exceeding both actual supply and the applicant pool. The state of flux in health service delivery has created an entirely new scenario. Addressing these shortages and systematically tracking factors affecting growth rates of the professions must be priorities for the Federal Government.

Federal Funding Role

To date, federal initiatives on behalf of the allied health professions have been scarce. It is alarming that such an important segment of the nation's health care workforce virtually has been ignored by Congress. The Omnibus Budget Reconciliation Act of 1981 included sparse appropriations for those sections which included allied health. Authorities for Sections 795, 796, 797, and 798, were only appropriated approximately $1 million and $.08 million in FY 83 and FY 84 out of a total health professions appropriations of $189.5 million and $198.4 million respectively (0.04 percent). In FY 87, no monies were appropriated for allied health of the total health professions appropriations of $200 million.

A bold, new federal initiative must be advanced to address the shortages in allied health personnel: shortages which are predicted to intensify for the remainder of this decade and through the year 2000--shortages which will impact negatively on the quality of care for an aging population.

The American Society of Allied Health Professions wishes to commend the sponsors of the S.2229, particularly Title IV which addresses many of the critical issues of the allied health professions. Since there has been virtually no federal assistance for allied health manpower funding since 1980, it is imperative that the proposed reauthorization of The Public Health Service Act, Title VII, address these concerns and provide sufficient resources to support those in the private sector who are working in partnership to reverse the negative trends in the provision of health care.

A strong and decisive federal role in support of allied health is crucial to the issues of quality assurance, cost containment, geographic and specialty distribution, minority representation, care for the aged, terminally ill, and bilingual groups, and equal access to health care.

With the dynamic nature of health care delivery and rapidly changing practice needs, the allied health education system must not remain static. The federal government must share responsibility with the schools of allied health, professional associations of allied health, and other non-profit health care institutions in addressing the critical needs in allied health education.

PROPOSED LEGISLATIVE ACTION

Again, the Society wishes to commend the sponsors of S.2229 for their insight into the needs of the allied health professions by proposing initiatives in Title IV for recruitment and training of students, traineeships for both entering and advanced students, faculty development, a data collection and reporting systems in allied health, and loans for allied health students.

SECTION 403. ALLIED HEALTH PROJECT GRANTS AND CONTRACTS

Section 403, Allied Health Project Grants and contracts will provide for special projects which will improve and strengthen the effectiveness of allied health administrators, program directors, faculty, and clinical faculty to improve and expand current educational programs and services. Such projects would impact both supply and quality of graduates to address the health care needs of our citizens. ASAHP is pleased such projects would include, but not be limited to the following:

1. Curriculum Development: Curriculum development in the allied health professions programs to include an expansion of the knowledge base in disease prevention and health promotion, gerontology and geriatrics, long term care, occupational health, home health care, hospice care, and the ethical implications of health care in these areas;

2. Interdisciplinary Programs: Interdisciplinary education and training programs involving multiple disciplines which work with the same population of patients (e.g., aging, disabled); and approaches which link clinical practice, education, and research; and

3. Demonstration Projects: Demonstration projects in educational institutions, with emphasis on innovative approaches which link clinical practice, education, and research in allied health.

Section 403 also addresses well the recruitment of individuals into the allied health professions. Increasing the representation of minorities in the allied health professions is important to meet the health needs of diverse cultures and ethnic groups. Allied health professions are among the limited number of occupations in the economy for which the employment outlook is uniformly favorable, representing an excellent avenue for social mobility for disadvantaged minorities. Minorities are substantially under-represented in educational programs for the relatively high-level allied health professional degree programs (i.e., baccalaureate and advanced).

In a presentation to the National Council on Health Professions Education, the National Society of Allied Professions emphasized, "there continues to be a consistent decline in the number of black students who enter allied health education programs. In 1973-74 minorities accounted for about 16% of allied health enrollments nationally. By 1980, the figure had declined to about 14%," with an approximate 10% decline in the number of black students enrolled in allied health programs between 1974 and 1988. Some of the reasons for the limited numbers of black and other minorities in the allied health professions have been cited:

- o Lack of career awareness among minority youth and parents about health professions;
- o Insufficient secondary educational preparation in the basic communication skills and basic sciences;
- o Lack of available educational opportunities at post secondary schools;
- o Inadequate financial support for students and programs; and
- o Poor multicultural training opportunities.

Qualified students should have an equal chance of entering the allied health professions, regardless of their financial background. Further, the health professions should be representative of all races and socioeconomic groups in the U.S.; there is evidence that such wide representation will improve the overall quality of health care. Studies have indicated that students tend to work or practice in the geographic area and the urban or rural settings where they grow up. Thus, careful student recruiting and career development may serve as a means of providing health care in isolated or underserved areas.

We commend, therefore, the federal initiatives in S.2229, Section 403, which address career development and recruitment of students in the allied health professions. We especially are pleased funds would be provided to assist schools of allied health and other private non-profit, and public agencies to develop and expand innovative recruitment and career development programs for the allied health professions. Such support would help to:

1. Identify talent for the allied health professions at the elementary, junior high school, high school, and college levels;
2. Identify talent for the allied health professions among the non-traditional adult students seeking a change in career paths.

3. Support model recruitment centers directed toward individuals 12-16 years of age; those enrolled in colleges who have not declared majors, and mature adults who wish to change careers.

4. Provide remedial and tutorial services prior to and subsequent to admission to allied health education programs; and

5. Provide support for innovative career development and mentoring programs, including transition from 2-year to 4-year institutions;

Section 403, Recommended Authorizations and Appropriations:
FY 89 $11.5 Million; FY 90 $14 Million; FY 91 $16.5 Million

The proposed authorization level at $4.8 million for FY 89, $5 million for FY 90, and $5 million for FY 91 severely limits the capability of addressing the concerns Section 403 intends to remediate. ASAHP recognizes Congress' desire to limit overall spending and recommends a re-evaluation of funding levels and priorities in all the health professions. ASAHP recommends an authorization of $11.5 million for FY 89 for allied health; $14 million for FY 90; and $14 million for FY 91 for Section 403.

SECTION 305. EDUCATIONAL ASSISTANCE TO INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS

ASAHP again applauds the sponsors for their recognition of the importance of supporting individuals from disadvantaged backgrounds to enter the allied health professions. Too, the criteria established for eligibility for subsequent grants is well conceived and justified.

To date, however, allied health has received minimal support under Section 787 of the Public Health Service Act. This section should be expanded to include more students in allied health programs. ASAHP recommends that 30 percent of the grants authorized in this section be awarded to allied health programs to increase the numbers of minorities and other disadvantaged individuals pursuing allied health careers.

In addition, ASAHP recommends HHS be directed to involve experts in allied health education in the grant review process to evaluate the proposed projects in the health professions.

Section 305, Recommended Authorizations and Appropriations:
30 percent set aside of Section 787 funds

SECTION 404. ALLIED HEALTH STUDENT TRAINEESHIP

ASAHP congratulates the sponsors of S.2229 for recognizing the need to assist students in allied health in meeting the costs of entry level education, particularly since most allied health education begins at the undergraduate level. Further, the stipend will be extremely helpful with the exemption from taxation.

ASAHP also understands that new language in S.2229 will provide loans to undergraduate allied health students through the Health Education Assistance Loan (HEAL) program.

These programs supporting students entering the allied health professions will help to ensure equity for all qualified individuals wishing to pursue careers in the allied health professions.

Section 404, Recommended Authorizations and Appropriations:
$4 Million for FY 89, $5 Million for FY 90; and $5 Million for FY 91.

SECTION 405. TRAINEESHIPS FOR ADVANCED TRAINING OF ALLIED HEALTH PERSONNEL

An area of particular concern for ASAHP's constituents has been the previous lack of federal support for pre- and post doctoral training progorams in allied health.

Changes in health care practice brought about by advanced technology, a more comprehensive understanding of the human system and cost containment efforts place increasingly more complex demands on therapists, technologists, and certain related disciplines. As more is demanded of the practitioner, more also is required of the educational system. To this end, more of the allied health professions require education and training at the post-baccalaureate level.

According to the survey of allied health collegiate programs conducted by the American Society of Allied Health Professions in 1980, 337 schools offered an aggregate of 1,471 graduate and doctoral level programs. Graduate programs can be found among the following Professions: speech-language pathology/audiology, dietetics/nutritions, occupational therapy, physical therapy, medical technology, and respiratory care among others.

Today neither the number nor the quality of program applicants, nor the education typically provided even the baccalaureate graduate is keeping pace with growing service demands and radically changing practices. Severe faculty shortages currently exist in a number of allied health programs. The American Occupational Therapy Association (AOTA) and the American Physical Therapy Association (APTA) have documented shortages in their professions for the past several years.

.n some cases, the allied health professional chooses practice to academia for economic reasons. Employment opportunities exist with excellent compensation for practitioners, while graduate education is costly. Allied health students are bearing an increasing financial burden because of the increases in tuition and fees at many schools and the decreases in student financial aid.

Without sufficient numbers of faculty, programs are forced to limit their enrollments, and without Ph.D. educated faculty, many programs are forced to close because faculty are unable to comply with the research expectations of the institutions.

A dilemma exists for schools and units of allied health. Resources are severely limited to support the faculty needed to maintain viable programs to attract and retain qualified students.

We gratefully acknowledge, therefore, the sponsors of S.2229 for recognizing this need with new federal initiatives for the advanced training of allied health personnel.

1. Doctoral Programs: New doctoral programs in the allied health professions must be developed and existing programs strengthened and expanded. Priorities should be given to those programs in the allied health professions with the most severe shortages as well as on those which impact the aging community. Efforts should be made (a) to increase the quality and quantity of faculty to teach and do research in allied health; and (b) to fund all aspects of doctoral program development, including planning, developing, expanding, and administering programs.

2. Pre- and Post-Doctoral Traineeships: Support for pre- and doctoral traineeships should be made available to prepare allied health professionals to teach and do research in allied health. Further, traineeships should be made available for practitioners to be prepared to conduct independent research, collaborate in interdisciplinary research, and stimulate and guide research important to advancing the knowledge base of the allied health professions.

Section 405, Recommended Authorizations and Appropriations:
FY 89 $9 Million; FY 90 $11.5 Million; FY 91 $15 Million.

As noted previously, the overall funding for Sections in S.2229 which relate to allied health is much lower than need justifies. Allied health has received no finanical support since 1980. Schools and programs of allied health desparately need support to retain faculty and develop the capacity of those persons interested in pursuing teaching and research careers in allied health.

SECTION 406. ALLIED HEALTH PROFESSIONS DATA

The need for a comprehensive system of data collection, analysis, and reporting on allied health workforce and allied health education has been echoed repeatedly in past years--most recently by the Institute of Medicine which is conducting a congressionally-mandated study on allied health personnel.

The groups collecting data—both federal and non-federal—are using different definitions, asking different questions, focusing on different education or practice settings, responding to different needs for data, fielding surveys to different populations, and focusing on different levels of occupational detail.

The American Society of Allied Health Professions, in a 1985 report to the Bureau of Health Professesions, Health Resources & Services Administration, noted that:

- o adequate data on allied health manpower are not available;
- o there is no central source that provides comprehensive data on the allied health professions;
- o data are generally not compatible, and levels of data reliability and consistency vary.

A multi-actor data collection system which would include the federal government, professional associations, educational institutions, accrediting agencies, and state agencies would alleviate many of these problems while providing a foundation for more accurate estimates of allied health supply and requirements.

In its Fourth Report to the President and Congress on Health Professions, (and again its Fifth Report), the Bureau of Health Professions reiterated:

> Sadly, demographic and socioeconmic characteristics and information concerning the geographic dispersion and work patterns of allied health personnel are unavailable. This lack of both cross-sectional and longitudinal data makes the description of supply arduous and the determination of requirements virtually impossible for most allied health occupations.
>
> ...We continue to report that very few fundamental data are available to answer even the most basic questions about how many personnel there are in some occupations, their rates of entry, what turnover can be expected, where they work, and what they do. Data on allied health personnel have been collected so infrequently and with such lack of uniformity across occupations that changes over time can only be roughly assessed.

The sponsors of S.2229 are to be congratulated for proposing a new federal initiative for allied health data collection and analysis.

ASAHP recommends that the collection and analysis of data on the allied health professions, including all data collection activities related to the utilization and distribution of allied health practitioners should be centralized. Such a system should address allied health education, practice, and research. The functions of the data system would be to (a) review and computerize all existing data bases; (b) identify existing data gaps; and (c) present recommendations for data collection and analysis activities to the Bureau of Health Professions.

A qualified outside agency, such as the American Society of Allied Health Professions (ASAHP), should be charged with the design and development of such a system. Because the American Society of Allied Health Professions represents the educational, research, and service delivery interests of allied health personnel, it is viewed as the logical manager of the system.

Section 406, Recommended Authorizations and Appropriations:
FY 89 $5 Million; FY 90 $7.5 Million; FY 91 $9 Million

CONCLUSION

Allied health services are essential to the well-being of the nation, and allied health education is equally essential. Allied health services depend on allied health education.

Formal education programs for most allied health professions are the only means of ensuring that a sufficient number of personnel will be adequately prepared. In addition, eligibility under all student aid and scholarship programs is essential to enable students to access formal education programs.

Moreover, the continued improvement of allied health services--their quality, cost effectiveness, access, and continuity--depends on allied health education. Without advanced programs and formal leadership development, it is unlikely that the necessary research and development activities will be conducted. These research and development activities can lead to improvement in services by improving educational processes and graduating better prepared practitioners.

The future of health care and health care delivery depends on financial support for allied health education and a renewed commitment on the part of the federal government to provide its fair share of that support. While "fair share" for allied health may indeed be defined differently by the members of Congress, physicians, dentists, nurses, and "allied health professionals," Congress needs to address both society's health care needs and the number of professions affected, including all of those defined under the rubric of "allied health."

S.2229 currently allocates $15 Million in Title IV for allied health. ASAHP has identified a minimum of $29.5 million for FY 89; $38 million for FY 90; and $45.5 million for FY 91 to address these same sections in Title IV of S.2229. ASAHP further recommends a 30% set aside in Section 305: $9 million for FY 89; $9.6 million for FY 90; and $10.2 million for FY 91.

I appreciate the opportunity to submit these comments on behalf of the American Society of Allied Health Professions. If you have any questions, or need further clarification, please feel free to contact Carolyn M. Del Polito, Ph.D., Executive Director of ASAHP at (202) 857-1150.

* * * *

Attachment A: ASAHP Member Organizations

Attachment B: Statements from the several ASAHP Member Organizations

Appendix A:

ASAHP MEMBER ASSOCIATIONS

American Association of Medical Assistants
American Association of Pathologists Assistants
American Association for Respiratory Care
American Kinesiotherapy Association
American Dental Hygienists' Association
American Dietetic Association
American Medical Record Association
American Medical Technologists
American Occupational Therpay Association
American Physical Therapy Association
American Society of Clinical Pathologists
American Society of Electroneurodiagnostic Technologists
American Speech Language Hearing Association
Association of Surgical Technologists, Inc.
Department of Allied Health Education & Accreditation, AMA
National Association of Medical Staff Services
New York State Registry of Medical Technology
Society of Non-Invasive Vascular Technology
Society of Nuclear Medicine, Technologists Section

Appendix B:

Statements from the following ASAHP Member Organizations

American Association for Respiratory Care

American Society of Clinical Pathologists

American Speech-Language-Hearing-Association

Technologist Section of the Society of Nuclear Medicine

AARC
AMERICAN ASSOCIATION FOR RESPIRATORY CARE 11030 Ables Lane, Dallas, TX 75229, 214/243-2272

The American Association for Respiratory Care (AARC), a 27,000 member professional association welcomes the opportunity to add its comments to the written testimony of the American Society of Allied Health Professions.

Respiratory care is a health care specialty performed under a qualified medical director for the assessment, treatment, management, diagnostic evaluation and care of patients with deficiencies, abnormalities and diseases of the cardiopulmonary system.

The AARC supports the provisions of S. 2229, the reauthorization of Title VII of the Public Health Services Act.

In 1987, the AARC conducted the first comprehensive manpower survey for respiratory care professionals in United States hospitals. Based on the manpower survey results, it is projected that there are 70,000 respiratory care FTE's employed in hospitals. It also projected that based on the survey results there are nearly 3,000 vacancies in hospital respiratory care departments.

In 1982 the AARC conducted a more limited manpower survey. In it, we projected a nationwide shortage of only 300 hospital respiratory care personnel vacancies. The increase over the last five years in the number of respiratory care vacancies is astonishing.

Demands for the services of respiratory care personnel are increasing. In 1987 the Association issued its Task Force Report on Professional Direction. The report combines the results of six surveys conducted by the AARC. The results show:

1. Hospital administrators (one of the survey groups) would prefer to expand respiratory care departments over other ancillary departments;

2. due to cost constraints on hospitals, respiratory care personnel are being utilized in other areas besides respiratory care;

3. there are increasing numbers of patients being admitted to hospitals with respiratory care related illnesses;

   and

4. these patients are being discharged into alternate care sites earlier.

The AARC conducted three surveys to ascertain the scope of respiratory care services and the utilization of respiratory care personnel in three alternate site providers: (1) skilled nursing facilities; (2) home health agencies; and (3) durable medical equipment providers. The survey results indicate that all three

Sponsored by the American College of Chest Physicians, the American Society of Anesthesiologists, and the American Thoracic Society

providers anticipate serving an increased respiratory care population, especially in the area of "hi-tech", that is in particular, ventilator care. Results also indicates a desire to hire respiratory care personnel.

Finally, we are all tragically aware of the spreading AIDS epidemic. As more and more patients fall ill with the disease, respiratory care personnel expect to be on the front line of care giving. Reported AIDS cases are projected to rise from the current 59,000 to a figure between 115,000 and 200,000 by 1991. One of the major diseases AIDs patients contract is pneumocystic carinii, a rare pneumonia. According to the latest CDC figures (April 18, 1988) 36,821 AIDS patients had contracted this respiratory illness. That represents over 60% of all AIDS patients. We anticipate an increasing need for respiratory care personnel in both the hospital and alternate care sites to treat the AIDS patient population.

The field of respiratory care recognizes two levels of practitioners, the certified respiratory therapy technician (CRTT) and the registered respiratory therapist (RRT). Very few of the "old" OJT's or "on the job trainees" remain in the field. The field of respiratory care has become far too complex to support practitioners who have no formal training. To that end respiratory care practitioners attend schools of respiratory care and sit for the professional credentialling exam. The Joint Review Committee for Respiratory Therapy Education (JRCRTE) accredits respiratory care educational programs across the country and the National Board for Respiratory Care (NBRC) administers the credentialling exams to the profession. Information from both organizations follows:

From JRCRTE:

The number of approved technician programs has dropped from a high of 198 in 1980, to 179 programs in 1986. The total number of applicants dropped from a 1983 high of 14,906, to 9,390, applicants in 1986. The total number of technician graduates increased slightly:

1985 - 3,078
1986 - 3,158

The number of therapist programs have fortunately increased. The number of accredited programs have risen from 192 in 1979 to 257 in 1986. We believe this reflects the growing realization that professional advancement and continued medical technology development necessitates the more highly trained therapist level. In spite of increased number of schools and enrollments for both first and second year placements during the early '80s, the downturn trend can be seen in 1986 numbers. Graduate figures show:

1985 - 3,375
1986 - 2,707

Preliminary 1987 numbers indicate that the decrease in the number of graduates continues.

From the NBRC:

In order to sit for either credentialling exam, applicants must meet the following criteria:

Certified Respiratory Therapy Technician (CRTT) must be a graduate of an AMA and JRCRTE approved school for either a therapist approved program, or a technician approved program.

Registered Respiratory Therapist (RRT) must be a graduate of an AMA and JRCRTE approved school for respiratory therapy, including 62 hours of approved college credit, plus one year experience working for a medical director of respiratory care.

All RRTs must have the CRTT credential, prior to sitting for the RRT exam.

Total number of RRTs - 29,337

Total number of CRTTs - 74,607

Candidate volume, i.e., all those who have taken both exams:

1986 - 29,000

1987 - 27,000

1988 - 25,000 (estimated)

There has been an approximate 10% decrease over the last two years for those sitting for the credentialling exams. NBRC attributes this fact to the decreasing school enrollments.

We believe that the data clearly shows that the demand for respiratory care personnel is increasing while the numbers of qualified practitioners are decreasing. The Association believes that S. 2229 will provide resources to help alleviate the shortage of all allied health personnel.

Respectfully submitted,

Gerald K Dolan

Gerald K. Dolan
President

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS
2100 WEST HARRISON STREET • CHICAGO, ILLINOIS 60612-3798 • (312) 738-1336

The American Society of Clinical Pathologists (ASCP), whose members and registrants exceed 140,000 allied health laboratory professionals, is pleased to have this opportunity to express its support of S. 2229, the Health Professions Reauthorization Act of 1988. The Society applauds the Committee on Labor and Human Resources for recognizing the need for federal financial assistance to allied health programs and students and for providing funding opportunities therein for the first time since 1981. It is becoming increasingly recognized that nursing is not the only health profession in which shortages exists. These shortages may be attributed to: 1) institutions having increasing difficulties in recruiting individuals to the allied health professions; 2) institutions facing increased budgetary restrictions; 3) students being discouraged from entering allied health professions due to the cost of health professions education; and 4) career entry level salaries being generally lower than other professions with a limited opportunity for economic advancement.

There has been a sharp decrease in the number of applicants to allied health education programs and the laboratory professions in particular. The general fear of contracting blood borne diseases such as Acquired Immune Deficiency Syndrome is discouraging many high schools students from choosing careers in the health professions, especially in the clinical laboratory. The overall number of high school graduates continues to decline. Additonally, allied health care has a perceived negative image by the general public accompanied by feelings of a "lowered status" among health care providers which is a disincentive to enter the professions.

The ASCP is engaged in activities to recruit qualified students into the field and to assist program development. Assistance from the federal government, however, is imperative. The grants/projects for allied health programs as well as the allied health student traineeships provided in Title IV of S. 2229 will provide that necessary federal financial assistance.

While ASCP supports S. 2229, the Society requests that the current definition of "schools of allied health" as contained in Section 701 (10) of the Public Health Service Act be changed to include those programs based in hospitals. According to the American Medical Association's Committee on Allied Health Education Accreditation, of the 2,083 allied health education programs throughout the country, 987, or 34.7% are considered hospital based. This means that the student attends the university for the first part of his/her education and spends the remaining year(s) of training in the hospital setting. In medical technology, 309, or 68.5%, of the 509 programs presently open, are hospital based. The accreditation process is the same for both university and hospital based programs. The quality of students produced by hospital based programs is as good as--and studies show in some instances better than--those trained in universities.

The ASCP recognizes that hospital based programs will be eligible to compete for most of the grant/contract opportunities provided in S. 2229. The language of the bill as drafted, however, would deny students in hospital based programs eligibility to apply for HEAL and Health Professions Student Loans. The lack of loan eligibility is a serious disadvantage for allied health students and may force them to decide against certain allied health careers. Hospital based programs and their students should not be discriminated against in this manner. In many geographic locations, the only training for a particular profession may be based in a hospital. This will result in fewer allied health professionals graduating in certain areas of the country, thereby accentuating the manpower shortage in those professions. The allied health professions most notably affected will be cytotechnology, medical technology, nuclear medicine technology, radiography, and radiologic technology. A generic description of hospital based programs is attached.

DESCRIPTION OF HOSPITAL BASED ALLIED HEALTH PROGRAMS

There are presently 2,843 allied health programs accredited by the American Medical Association's Committee on Allied Health Education Accreditation. Thirty-four percent, 987, are hospital based.

Hospital based programs meet the same accreditation criteria as those based in universities. Studies demonstrate that particularly in the laboratory field, students graduating from hospital based programs perform as well if not better than those who graduate from the university based program on national certification examinations.

A majority of the hospital based programs are affiliated with universities. The student attends the university for the first part of his/her education and spends the remaining year(s) of training in the hospital setting. Some students already have a baccalaureate degree before entering the hospital training program. In these situations, the hospital awards the student a certificate indicating successful completion of the program. For students who have not obtained their degree prior to the hospital training, the university will recognize the certificate and award academic credit. Hospital based programs have the same responsibilities in terms of curriculum development, faculty training, etc., as the university programs.

Hospital based programs face particular financial stress as a result of the Prospective Payment System (PPS). To account for limited reimbursement for inpatient care caused by the PPS, hospitals are forced to make cuts in areas such as allied health education programs which may not contribute directly to patient care and are costly for the hospital to operate. Medicare's direct pass-through for allied health education is not adequate financial support to keep the program open.

Tuition in hospital based programs may be as high as in the university based program. Students enrolled in hospital based programs need access to loan programs and other financial assistance. They are not eligible to apply for loans presently available under the Public Health Service Act.

While hospital based programs are traditionally much smaller than those based in universities, when hospital programs have closed, the universities have generally not expanded to take in extra students. Therefore, the reduction in training slots caused by the closure of the hospital based program is not made up. Additionally, some hospital based programs are located in areas that may not have a local college or university. The only available training program may be in a hospital. If the hospital program closes, the student may not have access to an educational program. This will lead to a manpower shortage in many geographic locations.

--ASCP WASHINGTON OFFICE-- (April 1988)

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Speech-Language Pathology and Audiology

1. Nature of the Profession

Speech-language pathologists and audiologists are health, rehabilitation and education professionals who provide services to people in all age groups who have communication disorders. Speech-language pathologists are specialists in the understanding and expression of human communication and its normal development, and in its disorders and the prevention of disorders such as articulation, voice, fluency, auditory and/or visual processing and memory and interactive communications. They determine the need for augmentative communication devices and provide individuals with training in the use of such devices. Audiologists are specialists in the prevention, identification and assessment of hearing impairments, and in the habilitation and rehabilitation of persons with hearing impairments, including the fitting and dispensing of hearing aids.

Speech-language pathologists and audiologists provide services to individuals with communication disorders resulting from congenital disorders (such as deafness in children), cancer (resulting in laryngectomy), stroke (resulting in aphasia), learning disabilities, head injury, and noise-induced hearing loss. Individuals with developmental disabilities and mental retardation may have related communication disorders and can benefit from rehabilitative services provided by speech-language pathologists and audiologists.

The American Speech-Language-Hearing Association (ASHA) awards the Certificate of Clinical Competence (CCC) to individuals with a master's degree who have completed a year of supervised clinical training and passed a national examination. Thirty-seven states have licensure laws in speech-language pathology and audiology and the requirements are generally similar to the CCC. There are over 240 graduate training programs in the field, the majority of which are accredited by the Educational Standards Board (ESB) of ASHA. The ESB sets the national standards for graduate education that are recognized by the U.S. Department of Education.

An estimated 24 million people in the United States suffer from hearing, speech or language disorders. The prevalence of hearing loss, according to the Health Interview Survey (1982) has been estimated to be 8.7% of the non-institutionalized population or 19.7 million Americans. Hearing loss is most common among the elderly, with one out of every four people over the age of 65 suffering from a hearing disorder. Speech and language impairments are most common among children and make up the second largest category of disabilities in the public schools. For the rest of this century and beyond, the numbers of persons with communication disorders will increase at faster rates than the total population.

2. Shortage of Speech-Language Pathologists and Audiologists

- A majority of nursing homes neither employ a speech-language pathologist and audiologist nor provide speech-language-hearing services, despite a reportedly high prevalence of communication disorders among their residents.

- An American Hospital Association survey showed that speech-language pathologists and audiologists ranked 7.5 (tied with occupational therapists) in vacancy rates among 34 professions.

- The Department of Education, in its Ninth Annual Report on the implementation of P.L. 94-142, found that more than 2,500 additional special education personnel were needed to serve speech and language impaired children.

- The Bureau of Health Professions reports that over two-thirds of all counties in the United States may have no available audiological services.

- There has been a serious decline in graduate program faculty in communication sciences and disorders. During the five-year period between 1982 and 1987, a loss of 215 full-time faculty positions (nearly 10%) has occurred.

- Minority representation in the profession is only about 4% and there was a disturbing decline in minority student enrollment in the early 1980s. Reductions in federal financial assistance appear to have been a leading cause of this trend.

3. Demand

- A recent study by the University of Georgia Institute of Higher Education found that 73% more hospital-based speech-language pathologist positions will be needed by 1995, the highest among any health care profession in the State of Georgia.

- A new report, Personnel for Health Needs of the Elderly Through the year 2020, by HHS, projects a dramatic increase in elderly persons with communication impairments. The report estimates that 17,700 full-time audiologists will be needed 30 years from now to serve elderly individuals with hearing loss -- more than double the current supply of audiologists. A huge increase in the number of speech-language pathologists needed to serve the elderly -- almost 24,000 by the year 2020 -- is also projected.

- The percentages of speech and hearing impaired persons aged 65 and over were 20% and 43% respectively in 1980, but will grow to 25% and 46% by the year 2000 and to 39% and 59% by the year 2050. As the communicatively handicapped population increases, so does the demand for qualified speech-language pathologists and audiologists to provide health care and rehabilitative services.

- As a result of the new requirements in P.L. 99-457 for services to infants, toddlers and preschool children with disabilities, many more qualified speech-language pathologists and audiologists will be needed to serve these age groups. Among 3 to 5-year-old children with disabilities, the vast majority (70.5% in the 1984-85 school year) had a primary handicap of speech or language impairment. This does not include the large number of children with other primary handicaps, such as mental retardation and cerebral palsy, who have concomitant speech or language disorders. All of these children require the services of qualified speech-language pathologists.

- From a need perspective, it is clear that more qualified professionals are needed to serve the estimated 24 million people in the United States who have speech, language or hearing impairments. With a workforce of approximately 86,000, the ratio of personnel-to-communicatively impaired population is 1:280, an imbalance which demonstrates that many additional speech-language pathologists and audiologists need to be trained to serve this large and growing population.

Statement of

Technologist Section of the Society of Nuclear Medicine

submitted to

Senate Committee on Labor and Human Resources

regarding

Health Professions Reauthorization Act of 1988

April 28, 1988

The Society of Nuclear Medicine and its component Technologist Section strongly support the provisions of S. 2229, the Health Professions Reauthorization Act (Title VII of the Public Health Services Act) as they relate to the critical needs of the allied health professions. The Society and Technologist Section together represent the Nuclear Medicine community of this country, with a membership of 12,000 physicians, scientists, technologists and other professionals actively engaged in research and the practice of Nuclear Medicine.

The rapidly shrinking allied health manpower pool and the growing demand for these professional have created a crisis situation in American medicine that threatens the access to quality medical care. This crisis is rapidly permeating the field of Nuclear Medicine as hospitals have been unable to recruit and retain the most qualified Nuclear Medicine Technologists (NMTs) at a critical time when our technology is rapidly advancing and improving our diagnostic and therapeutic capabilities. Because of the harsh economic environment resulting from the Prospective Payment System, the number of accredited schools of Nuclear Medicine Technology have been reduced by almost 20%, from 141 in 1985 to 115 in 1987. The reduction in the number of graduates is even more alarming: in 1984, 813 NMTs were graduated from accredited schools, while only 494 were graduated in 1987, a reduction of almost 40 percent.

A recent survey conducted by the Technologist Section of the Society of Nuclear Medicine reveals that over 57% of the Nuclear Medicine department directors surveyed recognize a shortage in qualified NMTs, while there has been an increase in the number of Nuclear Medicine studies performed. Seventeen percent of those surveyed reported that it is taking five months or longer to recruit NMTs in their departments.

Because of our grave concerns about the current and projected declining allied health manpower pool we fully your support the four-part plan developed by the American Society of Allied Health Professions that will address the allied health crisis which will only worsen through the year 2,000, and will adversely affect the quality of medical care. Specifically, we strongly support: federal assistance to expand recruitment and career development programs at allied health schools; federal initiatives to support faculty development and recruitment; federal support to create a national, comprehensive database to track trends and make projections for the supply of allied health professionals; and expansion of the Title VII programs to make students in allied health education eligible for loans that are currently only available for medicine, dentistry, osteopathy, etc. We also believe that the definition of "School of Allied Health" in Section 701 (10) should be expanded to include "other accredited public or private non-profit entities". Currently, hospital-based schools are not included in this definition, which excludes students in these programs from access to financial assistance under Title VII.

We in Nuclear Medicine are deeply committed to providing the highest quality medical services, and seek Congressional support for programs that ensure a full supply of the most qualified Nuclear Medicine technologists and other allied health professionals.

Senator MATSUNAGA. Thank you very much, Ms. Fitz. There is one area of controversy in considering Federal support for allied health involving hospital-based programs. What are the differences between hospital-based programs and those within schools of allied health?

Ms. FITZ. The most obvious, Mr. Chairman, is the difference in administration. The hospital-based programs are administered by a system which has as its primary mission, service. The educational programs are administered by a system which has as its primary mission, the education of students.

The hospital-based programs tend to have more block or continuous clinical experience as the mainstream of their programs. Educational programs tend to balance that throughout, particularly the last year in a community college, or the last two years in a four-year institution.

Lastly, I would comment that hospital-based programs offer a student a certificate, and educational institutions would offer a degree, either an associate degree, baccalaureate, or post-graduate. So those would be some initial differences.

Senator MATSUNAGA. Are hospital-based programs growing in number or becoming affiliated with schools of allied health?

Ms. FITZ. In the main, there has been a growing coalition between the health services area and higher education. I think you do note in certain professions that there is some growth in hospital-based programs. In the main, though, that is not pervasive. In the main, I would say that there are diminishing numbers of hospital-based programs, most especially in the laboratory field.

Senator MATSUNAGA. Are there differences in the quality of allied health professionals who train in hospital-based programs as against schools of allied health?

Ms. FITZ. I think that the standards used for assessing those programs tend to be the same as the years have gone on, and both have existed side-by-side for a longer period of time. I think there are scattered studies, but I think there is no way, really, to make a definitive statement that there are differences in quality. I think the prevailing opinion is that there are similarities in quality between both kinds of programs.

Senator MATSUNAGA. How has the AIDS crisis impacted upon recruiting students for allied health training programs, if at all?

Ms. FITZ. I think it has changed some of the ways we look at recruitment, and I think we have needed to be more specific, provide more information to students. We have had to do some additional education similar to what is done in school systems or in the population in general, in addition to regular recruitment activity. So I think the major difference it has had is that we receive more questions as educational institutions about AIDS and its impact in the system and what would this be like, particularly from parents.

But we find with additional education that most questions can be satisfied.

Senator MATSUNAGA. In your testimony, you have asked for higher funding for the allied health section of S. 2229 in excess of the $15 million in new dollars. In light of budget deficits and efforts to restrain Federal spending, increased funding would be difficult, as you heard the witness from the Administration testify to.

What would you say to the more conservative members of Congress, especially those who listen to the White House, to justify this additional authorization?

Ms. FITZ. Well, I think first I would go back to a comment I made about the ability of our groups to work together. We offer you a cadre of health professionals who are willing to come together in legislative language, in our practice, in our educational institutions, to solve problems in an integrated health care system so that elderly clients do not deal with fragmented services, and we keep the quality up. I think that is a real opportunity.

Secondly, allied health has had no funding for its educational programs, which may relate to my colleague's comment about the lack of trained professionals, and so we may be making up for some years of nonfunding.

And lastly, I think we do want to avoid a crisis in manpower, and I think this is the time for us to begin working on that issue in both our education and service arenas.

Senator MATSUNAGA. Well, thank you very much. I wish we had a little more time for questions, but we have other panels.

Thank you, thank you both.

Our next panel of witnesses consists of Dr. Cecil Samuelson, Dean of the School of Medicine, University of Utah; and Dr. Stephen Wotman, Dean of the School of Dentistry, Case Western Reserve University, Cleveland, Ohio.

Dr. Samuelson, I am sorry that Senator Hatch, who had intended to be here to introduce you, had to leave. I understand he was here earlier to meet with you. But that's the way it goes; we need to be at four or five different places all at the same time. So we will be happy to hear from you, Dr. Samuelson.

STATEMENTS OF DR. CECIL SAMUELSON, DEAN, SCHOOL OF MEDICINE, UNIVERSITY OF UTAH, SALT LAKE CITY, UT; AND DR. STEPHEN WOTMAN, DEAN, SCHOOL OF DENTISTRY, CASE WESTERN RESERVE UNIVERSITY, CLEVELAND, OH

Dr. SAMUELSON. Thank you, Mr. Chairman.

My name is Cecil O. Samuelson. I am Dean of the University of Utah School of Medicine and also a member of the Association of American Medical Colleges, known as AAMC, Council of Deans.

I am pleased to be presenting the views of the Association on the reauthorization of Title VII of the Public Health Service Act.

We appreciate this opportunity to testify concerning Title VII and the important roles that its programs play in addressing the health care problems of the Nation.

We commend Chairman Kennedy for his leadership and cosponsorship in introducing S. 2229, the Health Professions Reauthorization of 1988. I also appreciate the support of Senator Hatch and other members of the Committee for their efforts for the health professions.

S. 2229 recognizes the fundamental role health manpower programs play in addressing the Nation's health care problems and clearly reaffirms Federal support for health professions education.

The AAMC supports the provisions in S 2229 and believes they will continue the important national effort to broaden access to medical education and to ensure the availability of primary care physicians.

The Title VII programs of greatest concern to us are the student financial aid programs, the minority and disadvantaged recruitment and retention programs, the primary care training programs, the geriatric training and faculty development programs, and the area health education centers program.

Were it not for the financial aid programs in Title VII, the cost of medical education would be insurmountable obstacles for many aspiring, talented, but economically disadvantaged students. Tuitions have increased dramatically over the last decade. In private schools, the average first-year tuition in 1987-88 was $15,907. The average first-year tuition for in-State residents in public schools was $5,196 and $11,490 for nonresidents.

To finance the cost of attending medical school, most students would have to incur substantial debt. Of the approximately 82 percent of students who borrow, the average student in 1987 graduated with an educational debt in excess of $35,000. Twenty percent of medical student graduates had debts in the range of $50,000 to $75,000.

To uphold the goal of equal access and to ensure that every capable student regardless of income has an opportunity to attend medical school, the Federal student financial aid programs must be continued and expanded wherever possible. They should be a balanced portfolio of scholarships to the impoverished, subsidized loans for students with substantial need, and market rate loans for those who are financially able.

We believe that the financial aid provisions of S. 2229 constitute a balanced portfolio. The credit ceiling set for HEAL will enable this nonsubsidized market rate loan to continue to be available as a loan of last resort to health profession students.

The capital contribution for HPSL will help bolster this long-neglected revolving loan program that provides subsidized loans to students with exceptional financial need.

In the area of scholarships, we support the change made in S. 2229 to allow needy students in all four years to be eligible for the exceptional financial need program. This is especially important in light of the loss of the scholarship support once provided by the National Health Service Corps. Ideally, the EFN program would be large enough to assist all eligible students at all institutions.

In fiscal year 1987, 405 awards were made, but 1,319 who also met the eligibility requirements did not receive Federal support. Although S. 2229 provides the program with an authorization of $20 million, which is $13 million more than its current level, the AAMC believes this amount will be inadequate to help the larger number of needy students in all four years of medical school.

Title VII also currently provides scholarship support through the financial assistance to disadvantaged health profession students. In fiscal year 1987, 3,900 students met the eligibility requirements for this award. With an appropriation of $5.4 million, however, only an estimated 1,100 students received financial support.

We believe this scholarship support is very important, and we are concerned that the present legislation eliminates this program. We are not convinced that the funding increase the bill provides the EFN program will make up for the loss of this scholarship support.

To compensate, we believe either an identical, self-standing program should be established, or the authorization level for the EFN program should be further increased.

Title VII also plays an important role in the effort to increase the number of under-represented minorities in medicine. The disadvantaged assistance program has helped participating medical schools establish and maintain a number of effective recruitment and retention programs. These programs have helped increase the applicant pool and reduce the attrition rates of minorities in medical school.

While the AAMC commends the strong support in S. 2229 for the HCOP program, we believe that some refinement is needed in the new provision which requires that HCOP programs increase enrollment of disadvantaged students by 20 percent at the sponsoring institutions. We recognize the constraints on the budget, but are fearful that this standard would create problems for excellent programs with low numbers of students.

We appreciate also the support for our primary care programs and also the efforts to expand the number of primary care physicians in family practice, general internal medicine and general pediatrics.

The Title VII programs make important contributions for the needs for students and physicians in geriatric health care and a number of other important emphasis areas.

We appreciate the opportunity to express these views.

Thank you.

[The prepared statement of Dr. Samuelson, with an attachment, follows:]

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

On

Reauthorization of Title VII of the Public Health Service Act

Presented

April 28, 1988

Senate Committee on Labor and Human Resources

by

Cecil O. Samuelson, M.D.

Dean

University of Utah School of Medicine

aamc

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0525

Mr. Chairman, and Members of the Committee, the Association of American Medical Colleges (AAMC) appreciates this opportunity to testify concerning the federal programs supporting health professions education and the important role these programs play in addressing the nation's health care problems. Since its founding in 1876, the AAMC has broadened its membership to the point where it now serves as the national voice for all 127 U.S. accredited medical schools and their 66,000 students; 435 of the major teaching hospitals; and 85 academic and professional societies. Day to day, AAMC's membership is engaged in the major activities -- teaching, research, and patient care -- that together constitute medical education.

Introduction

The AAMC commends Chairman Kennedy for his leadership in introducing, S. 2229, the Health Professions Reauthorization of 198 S. 2229 recognizes the fundamental role health manpower programs play in addressing the nation's health care problems and clearly reaffirms federal support for health professions education. The AAMC supports the provisions in S. 2229 and believes they will continue the important national effort to broaden access to medical education and to ensure the availability of primary care physicians. Although we have concerns about specific provisions in the legislation, which we will discuss later, we hope the Members of this Committee will support the bill and press for its passage in the full Senate.

America's health care problems are well-known to the Members of this Committee. Added to persistent problems of access caused by inadequate numbers of primary care practitioners and geographic and supply imbalances are more recent concerns involving our ability to meet the health needs of the nation's fast growing elderly population. At the same time, our newest challenge, the AIDS epidemic, is complicating every aspect of the health care system.

In the early 1960's, the federal government identified the need for sharp increases in the number of physicians. In partnership with the nation's medical schools, the federal government, through the 1963 Health Professions Educational Assistance Act and its successors, helped expand the capacity of the educational system. Enrollments were increased and, by the mid-1970's, the number of graduating medical students had almost doubled from a decade earlier. (The enrollment statistics for the past 28 years appear as Attachment A to this statement.)

While recent debates have been focused on the issue of determining whether our nation is headed for an over-supply of physicians, resources have been directed toward addressing shortages in primary care areas. Concurrently, the government's commitment to ensuring equal access to medical education for economically and educationally disadvantaged students, present throughout its involvement in health manpower, has continued to be a priority in Title VII.

The target of the federal commitment to health professions education has been altered, but it is as important today as it was in 1963. While we believe a five-year extension of the current authorities would facilitate planning and enhance programmatic stability, we nonetheless support the three-year renewal provided by S. 2229.

The Title VII programs of greatest concern to the AAMC are the student financial aid programs, the minority and disadvantaged recruitment and retention program, the primary care residency training programs, and the special initiatives authority that has made possible the establishment of geriatric education centers and the start of a geriatric faculty development program.

Student Financial Assistance

The AAMC continues to believe that medical students should as much as possible pay for their own education, whether through family and individual resources or through borrowing. Nonetheless, we also think that promising applicants should be accepted regardless of financial status and ability to pay We believe it is good social policy to ensure that students who are capable of becoming physicians are not precluded from doing so because of the cost of medical education.

Tuitions have increased dramatically over the last decade. In private schools, the average first-year tuition in 1987-88 was $15,907. The average first year tuition for in-state residents in public schools was $5,196 and $11,490 for non-residents. Only 18% of students will graduate debt-free in 1988.

The period of training to become a physician is long and arduous, usually extending a minimum of seven years beyond the baccalaureate degree. The medical school curriculum and the structure of medical school is so rigorous and demanding that outside employment to help defray expenses is virtually impossible.

Eighty-two percent of all graduates borrow to finance their education. Of students who borrow, the average medical student in 1987 graduated with an educational debt of $35,621. Twenty percent of medical school graduates had debts in the range of $50,000 to $75,000. (Data on the mean debts of senior medical school students appear as Attachment B to this statement.)

Without Title VII student financial aid programs, only students from the upper and upper-middle classes would be able to become physicians. To uphold th goal of equal access and to ensure that every capable student, regardless of income, has an opportunity to attend medical school, the federal student financial aid programs must be continued and expanded wherever possible. There should be a balanced portfolio of scholarships to the impoverished, subsidized loans for students with substantial need, and market rate loans for those who are financially able.

O The Exceptional Financial Need Scholarship Program should be authorized at levels high enough to help meet the financial needs of more than one or two eligible students per institution. We support the change made in S. 2229 to allow needy students in all four years to be eligible for the EFN scholarship. This is especially important in light of the loss of the scholarship support once provided by the National Health Service Corps. We also support the flexibility S. 2229 accords the financial aid administrator in determining the size and number of scholarships to be awarded.

Ideally, the program should be large enough to assist all eligible students at all institutions. In FY 1987, 405 awards were made, but 1,319 who also met the eligibility requirements did not receive federal support. Although S. 2229 provides the program with an authorization of $20 million, $13 million more than its current level, the AAMC believes this amount will be inadequate to help the large number of very needy students in all four years of medical school. Just to meet the needs of the same 405 students in all four years would require an authorization of $28 million.

O The scholarship support provided through the Financial Assistance to Disadvantaged Health Professions Students (FADHPS) is also a much-needed source of financial aid to disadvantaged students with exceptional financial need. In 1987, 3,900 students met the eligibility requirements for this award. With an appropriation of $5.4 million, only an estimated 1,100 students received financial assistance.

S. 2229 eliminates this program. The AAMC believes this scholarship support is very important and we are not convinced that the funding increase in the EFN program provided by S. 2229 will make up for the loss of FADHPS. We understand that when Congress created this program in the last reauthorization of Title VII, it drew its authorization of appropriations from the Disadvantaged Assistance program authority in Section 787. If S. 2229 eliminates FADHPS in order to undo this relationship, AAMC believes that, to compensate fairly, either an identical self-standing program should be established or the authorization level in the EFN should be further increased.

0 The Health Professions Student Loan (HPSL) Program is a campus-based revolving loan fund which makes relatively low interest -- 9 percent-- loans to health professions students on the basis of need. Medical students must meet the exceptional financial need standard. In 1986-87, HPSL provided loans to 9,800 medical students. Although the HPSL loan is designed to provide support for both educational expenses up to $2500 plus the cost of tuition, in recent years loans have diminished to such a point that the average loan now totals $2,500.

Past problems with defaults in the HPSL program have been addressed. The most recent report from HHS on delinquent HPSL loans indicates that the rate for allopathic schools was 2.52 percent and 2.64 for all health professions disciplines. These are well below the maximum allowable rate of 5 percent.

The HPSL revolving fund has not been provided new capital for a number of years. Since it assists only the very neediest medical students, an additional capital investment is warranted. Acknowledging this neglect, S.2229 provides a capital contribution for HPSL which should help bolster its long-term viability. The AAMC supports this capital infusion as well as the bill's revision allowing all institutions to be eligible to receive redistributed funds. We hope the Committee will make clear that new capital funds and any loan funds returned to the federal government should be used exclusively for the HPSL program.

0 The Health Education Assistance Loans (HEAL) Program is a federally-insured unsubsidized market rate loan which is considered the loan of last resort for students who have no other way to meet the cost of their education. An insurance premium of 8 percent is charged to offset defaults, so the program requires no direct federal outlays.

While HEAL borrowing is discouraged to the extent possible because high cost HEAL loans increase indebtedness dramatically, the percentage of medical students borrowing HEAL loans has grown from 3.8% in 1980-81 to 20.2% in 1985-86. An increase in the borrowing limit to $7,500 for graduate students under the Guaranteed Student Loan program, may serve to lessen dependence on HEAL, but the program remains an important source of loans of last resort for students. The credit ceiling for HEAL should, therefore, be increased to ensure loan availability for all students who need them. The levels provided in S. 2229 should be sufficient in this regard.

The AAMC opposes the Administration's recent proposal to limit and weaken the HEAL program and appreciates the fact that S. 2229 rejects this approach. Requiring risk sharing by insuring only 80% of the HEAL loan and eliminating the 8% ceiling on the insurance premium would discourage lenders from offering loans and would make them too costly for borrowers.

The AAMC also supports the statutory language added to Title VII by S. 2229 to preclude the use of apportionment of HEAL loans. In the past, HHS has attempted to ration HEAL borrowing through apportionment of HEAL credit authority. Apportionment creates serious disruptions in the processing of loans and does not result in savings for the federal government. The prohibitions against this policy that Congress has enacted annually in appropriations measures will be made permanent as a result of this statutory change.

The AAMC supports efforts to promote collection of unpaid debts and encourages the Committee to permit the sale without recourse of loan default claims to eligible lenders. We also believe HHS should be required to use a formula for the determination of the default rate which estimates the amount of loans in default more accurately. Such a formula would take into consideration defaulted loans that are now in repayment status. In 1987, the amount of loans in repayment status represented 25 percent of the loans classified by HHS as being in default status. AAMC also supports the efforts that should be made by HHS to address the loans in collection status and believes due diligence procedures should be required on loans purchased by secondary markets.

For both HPSL and HEAL, existing loan repayment authority (Sections 741(f)(1) and 735(c)(1)) should be activated to help young physicians eliminate their debts through service in a manpower shortage area. Under the leadership of the Chairman of this Committee, a loan repayment program in the National Health Service Corps was established last year. However, the FY 1988 funding level will enable only a very few -- perhaps 60 -- physicians to take advantage of this mechanism for debt abatement. The number of health manpower shortage areas in the U.S. remains high and recent HHS estimates indicate that 4,200 primary care physicians are needed to meet the health care needs of the 13.4 million Americans living in underserved areas.

Any direction this Committee could provide to activate the existing loan repayment provisions in HPSL and HEAL would be beneficial. Coordinating the resources with the NHSC loan repayment program would enable many more physicians to take advantage of debt repayment and the opportunity to provide much-needed health care services in underserved areas. Loan repayment would also be a very beneficial program for future academicians and biomedical researchers. Extending this option to talented young physician scholars would assure that high debts do not preclude entrance into these important careers.

Concern has been expressed about the possible relationship between student indebtedness and choice of specialty and practice location. A number of observers have speculated that lower-paying primary care specialties are not as readily chosen because the high education debt eliminates the primary care option. HHS' November 1986 analysis of financial disincentives to career choices in health professions found no hard evidence to confirm a cause and effect relationship between indebtedness and career choice. The report did find, however, that increases in debt from nonsubsidized HEAL loans tended to reduce the likelihood of a physician choosing a primary care specialty. It also noted that increases in applications and enrollments of disadvantaged and minority students were greatest during the period when scholarships and low interest loans were readily available. The AAMC is exploring the question of indebtedness and career choice and we concur in HHS' opinion that new studies and continued monitoring would be useful in order to more conclusively define the relationship between educational indebtedness and career choice.

Underrepresented Minorities and Disadvantaged Assistance

Title VII also plays an important role in the effort to increase the number of underrepresented minorities in medicine. The Disadvantaged Assistance Program, Section 787, is the government's chief program for increasing minority representation in health careers. The program, known as the Health Careers Opportunity Program (HCOP), provides grants to schools and other non-profit institutions to support the identification, recruitment, admission, retention, and placement of minority and disadvantaged students in health professions schools. This support has helped participating medical schools to establish and maintain a number of effective recruitment and retention programs, including pre-matriculation courses, basic science enrichment courses, health careers information workshops, and academic assistance and tutorial programs. Together these initiatives have helped increase the applicant pool and reduce the attrition rate of minorities in medical school.

Overall, the increase in the enrollments of underrepresented minorities has been modest. After a sharp rise in the mid-1970's, the rate of increase in enrollments plateaued. Enrollment of Blacks has remained in the 5.7-6.0 percent range for the past decade. Enrollments of Hispanics and Native Americans were very low in 1970; gains since then have been 1.5 percent and 0.4 percent respectively. (Selected Minority Group Enrollments for the past 20 years appear in Attachment C of this statement.) These increases are not sufficient and our goal should continue to be the achievement of a minority physician population that more closely matches the demographic composition of minorities in our society.

The Disadvantaged Assistance program in Title VII is an essential component in our efforts to achieve a laudable and necessary goal, a goal to which the nation's medical schools and the federal government have been long and deeply committed. The AAMC recommends that the current Disadvantaged Assistance program be extended with a funding ceiling of $32 million in fiscal year 1989 and allowing annual incremental increases of $2 million.

While the AAMC commends the strong support provided in S. 2229 for the HCOP program, we believe some refinement is needed in the new provision which requires HCOP programs to increase enrollment of disadvantaged students by 20 percent at its sponsoring institution in order to be eligible for future program grants. The AAMC understands the concept of a performance standard and agrees that in some instances certain mandates may be necessary to gauge the quality and strength of programmatic efforts and institutional commitments. However, as currently designed in S. 2229, the performance standard would unfairly penalize some very effective HCOP programs.

The AAMC would prefer a standard which gives consideration and credit to successful programs whose participants, for a variety of reasons, do not matriculate into the institution sponsoring the program, but who do, nonetheless, enter a medical school somewhere in the nation. An institution's enrollment of disadvantaged students is affected by a number of factors that are beyond its control. Even though an institution may have accepted a high percentage of disadvantaged and underrepresented minority students, often it may not be able to offer enough financial aid to enable to all the students to attend its school.

The AAMC also supports the Excellence in Minority Health Education and Care Program (Section 788A). This program provides grants to the historically-black health professions institutions that have been responsible for training a large number of minority health professionals. The funding helps these schools alleviate critical financial problems that threaten their survival and also assists them in serving as national resources for efforts to increase minority representation in the health professions. Congress provided $9.7 million in FY 1988 for this program and the AAMC believes this level of funding should be provided throughout the program's authority.

Primary Care Training

Other Title VII programs of importance to AAMC are those which address the nation's need for additional primary care physicians and their broader geographical dispersion into underserved areas. Since 1976, Title VII programs have provided crucial financial assistance to schools of medicine and teaching hospitals to help provide an environment in which training in primary care can flourish. This federal support has increased the number of primary care physicians and been successful in strengthening the nation's health care delivery system.

The Family Medicine Residency and Training Program in Section 786 will support approximately 3,779 residency positions in FY 1988. Faculty development in the family medicine program will provide exposure to family medicine for 1,771 individuals, and the number of students benefiting from predoctoral projects is expected to be 13,100. The number of family practice residencies increased dramatically between 1968 and 1982, but in 1983, the growth of family practice residents diminished and the number of residents actually declined slightly in 1986. Coincidentally, federal support of family medicine residencies began to level off in 1983.

Patient revenues have not been able to support family medicine residency training programs in part due to the fact that payment for service and education in the ambulatory setting is not at the same level and scope as it is for the hospital inpatient setting. The family medicine residency programs, thus, depend more heavily on federal support. According to an HHS analysis of the impact of federal support on family practice residency training, the absence of federal funding makes programs 3.7 times more likely to fail than programs receiving funds. Since the majority of family practice programs are located in community hospitals, the loss of federal funds would affect community-based programs, the traditional primary care sites, more severely.

The financial underpinning of family medicine departments in medical schools has the same problem as the family medicine residency programs. These Departments need federal support. The Departments of Family Medicine Program in Section 780 has expanded the number of academic administrative units providing clinical instruction in family medicine. The program is funding 57 projects in FY 1988 and providing 11,400 medical students exposure to the discipline of family medicine.

The General Internal Medicine and General Pediatrics Residency Program in Section 784 is training 1,756 residents and 323 faculty members in FY 1988. These federally-funded residency programs have been very effective in increasing the number of general internists and general pediatricians. A recent report by John Noble, M.D. of Boston University Medical Center for HHS' Division of Medicine shows that federally-funded programs produce more primary care physicians than traditional residency programs: 80% of federally-funded residents remain in general internal medicine whereas only 38% of nonfederally funded program graduates do; in pediatrics, 74% of those in federal programs stayed in primary care while only 48% of nonfederal program trainees remained generalists.

Dr. Noble's study also showed that federally-funded general internal medicine and pediatric residency programs were also qualitatively more involved in the process of primary care education, having well-defined, and closely monitored and continually evaluated curricula and a strong administrative structure. Among the characteristics of the federally-funded primary care training program are greater exposure to continuity of care settings, more comprehensiveness in clinical rotations, greater diversity in community-based training sites, the inclusion of ethics, behavioral science, and geriatrics curricula, and a well-established interdisciplinary approach to primary care delivery. It is these very important characteristics that will suffer in the absence of federal support.

Title VII primary care training programs have succeeded in increasing the number of primary care physicians and in enhancing the quality of the primary care provided. Without these programs the nation would be farther behind in meeting the health care needs of children, the indigent, the elderly, and the homeless. Title VII programs should be extended and authorized at levels high enough to produce more primary care physicians. Section 780, Departments of Family Medicine, should receive $15 million in FY 1989 and levels in the following years should be set to allow for inflationary increases. The family medicine residency program in Section 786 should be funded at levels of $50 million each year. The Section 784 residency training programs in general internal medicine and general pediatrics should receive $23 million in FY 1989 with add-ons of 1 million each year. The levels of support provided in S. 2229 for these programs is less than our recommendations and we hope the Committee will be able to revise these authorization levels upward. Also, we believe no effort should be made to change the relationship in S. 2229 between the family medicine and general dentistry programs unless no harm is done to the much-needed funding level for family medicine residencies.

Geographic Distribution

Title VII has also been effective in increasing the distribution of physicians. The Area Health Education Centers (AHEC) Program (Section 781) supports the dispersion of primary care physicians and other health care professionals into shortage areas by decentralizing the conduct of health professions education. Under the current program, participating medical schools, which must provide 25% of the project's funding, are required to carry out 10% of their undergraduate clinical educational program in an AHEC. AHECs are located away from the medical school campus in underserved areas with high proportions of Native Americans, Blacks, Hispanics, and low-income populations.

In FY 1987, 29 projects were funded which served 247 counties in 23 states, 12,830 students received training in the program. AHECs have been very effective in helping to decentralize medical education and, in the process, they have provided much-needed primary health care services in shortage areas. The AAMC believes the program should be extended and expanded to $25 million each year.

Geriatric Training and Faculty Development

Title VII's special initiatives authority in Section 788 enables emerging health care problems to be addressed. Recent demographic changes and growth in the population of elderly citizens have increased the need for physicians trained in geriatric medicine and Section 788 has earmarked funds to strengthen and coordinate multidisciplinary training in geriatric health care. The Geriatric Training Program in Section 788(d) has helped establish 34 geriatric education centers throughout the United States. The Centers provide short-term faculty training, curriculum and other educational resource development, technical assistance, and outreach. The programs are multidisciplinary and are affiliated with other educational institutions, chronic and acute care hospitals, community-based centers for the aged, ambulatory care centers, nursing homes, and VA hospitals. Many centers include geriatric evaluation units that function as centers for clinical training. These also serve to provide both continuing education and clinical rotations for medical and other health professions students.

The other authority in Section 788 (Section 788(e)), established by P.L. 99-660, provides funding for Faculty Development in Geriatrics. Congress provided about $3 million for FY 1988 and the Division of Medicine in HRSA has just begun to accept grant applications for this year.

The grants will enable schools of medicine, teaching hospitals, and graduate medical education programs to support fellowships for academicians and researchers. These fellowships will prepare them to effect changes in the curricula and patient care delivery systems that are essential to accommodate the anticipated needs of the elderly and to direct research projects addressing the health care problems of the aging. The development of both curriculum and able teachers and researchers is critical to attracting medical students into geriatrics and to ensuring that a growing demand and need will be met.

AAMC supports the geriatric training and faculty development authorities and the appropriate role they play in intensifying the focus of medical educators in gerontology and geriatric medicine. The geriatric training and faculty development programs enhance the well-established federal role in the Medicare program, and the AAMC believes the Committee should extend them at adequate funding levels. In past years, some funds for Section 788(d) have been drawn from Section 301 indicating the existing authorization level is inadequate. We support the authorization ceilings provided in S. 2229 as well as its separation from the authorities in the special initiatives section. A self-standing section for these programs would reflect their priority and give recognition to the fact that the aging of the population is a well-established concern with long range implications.

Preventive Medicine

S. 2229 places the Preventive Medicine Residency Program in a restructured special projects section. The AAMC believes preventive medicine should continue to receive adequate funding under this new arrangement.

Conclusion

Title VII represents a successful partnership between the federal government and the nation's medical schools and teaching hospitals which has had demonstratably beneficial results for the American people. Access to medical education has been improved; the quality and number of primary care educational programs and primary care physicians have increased; and, the number of minority physicians has grown. While the debate about the question of overall physician supply continues, it is clear that federal support should continue to be targeted to student assistance, minority recruitment, and expanded primary care training opportunities. Title VII is a relatively small program but its influence on the nature and quality of the nation's physician supply has been remarkable, Congress should enable this important health manpower policy program to continue.

Thank you for your consideration of these views.

aamc association of american medical colleges

ATTACHMENTS

to AAMC Testimony

before the

Senate Committee Labor and Human Resources

on Reauthorization of Title VII

of the Public Health Service Act

April 28, 1988

One Dupont Circle, N.W./Washington, D.C. 20036 / (202) 828-0400

ATTACHMENT A

TABLE B1

MEDICAL SCHOOL APPLICANTS, ENROLLMENT, AND GRADUATES

Class Year	Applicants	First Time Applicants	Accepted Applicants	Applicants/ Acceptance Ratio	First-Yr. New Entrants	First-Year Enrollment*	Total Enrollment	Graduates
1960-61	14,397	—	8,560	1.7	7,845	8,298	30,288	6,994
1961-62	14,331	—	8,682	1.7	7,941	8,483	31,078	7,168
1962-63	15,847	—	8,959	1.8	7,993	8,642	31,491	7,265
1963-64	17,668	—	9,063	1.9	8,107	8,772	31,981	7,336
1964-65	19,168	—	9,043	2.1	8,288	8,856	32,428	7,409
1965-66	18,703	—	9,012	2.1	8,554	8,759	32,835	7,574
1966-67	18,250	—	9,123	2.0	8,775	8,964	33,423	7,743
1967-68	18,724	—	9,702	1.9	9,314	9,479	34,538	7,973
1968-69	21,118	—	10,092	2.1	9,740	9,863	35,833	8,059
1969-70	24,465	—	10,547	2.3	10,269	10,422	37,669	8,367
1970-71	24,987	—	11,500	2.2	11,169	11,348	40,487	8,974
1971-72	29,172	—	12,335	2.4	12,088	12,361	43,650	9,558
1972-73	36,135	—	13,757	2.6	13,570	13,677	47,366	10,396
1973-74	40,506	—	14,335	2.8	13,876	14,154	50,751	11,365
1974-75	42,624	—	15,066	2.8	14,579	14,763	53,554	12,716
1975-76	42,303	—	15,365	2.8	14,910	15,295	55,818	13,634
1976-77	42,155	—	15,774	2.7	15,282	15,613	57,765	13,614
1977-78	40,569	—	15,977	2.5	15,493	16,136	60,039	14,391
1978-79	36,636	—	16,527	2.2	16,054	16,501	62,213	14,966
1979-80	36,141	—	16,886	2.1	16,444	16,930	63,800	15,135
1980-81	36,100	—	17,146	2.1	16,590	17,186	65,189	15,673
1981-82	36,727	26,621	17,286	2.1	16,660	17,268	66,298	15,985
1982-83	35,730	25,597	17,294	2.1	16,567	17,254	66,748	15,802
1983-84	35,200	25,317	17,209	2.0	16,480	17,150	67,327	16,343
1984-85	35,944	26,059	17,194	2.1	16,395	16,997	67,016	16,318
1985-86	32,893	23,517	17,228	1.9	16,268	16,963	66,585	16,117
1986-87	31,323	23,141	17,092	1.8	16,103	16,819	66,125	15,830
1987-88	28,123	20,977	17,027	1.7	15,927	16,713	65,735	

*Includes new entrants and those repeating the initial year.

Sources--Prior to 1947-48 from Potthoff, E.F., Journal of Medical Education 35 (1960), p. 223. Applicants and accepted students: Applicant studies of AAMC 1930-31 through 1978-79, published annually in Journal of Medical Education. Since 1978-79 from AAMC Section for Student Services (Final Admission Action Summary Reports).

Enrollment data: 1930-31 through 1967-68 from JAMA Education Numbers; Since 1968-69 from AAMC Section for Student Services (Fall Enrollment Questionnaire).

Graduate data: 1930-31 through 1967-68 from JAMA Education Numbers; 1967-68 to 1981-82 from LCME Part II; since 1982-83 from AAMC Section for Student Services (Student Records System).

Because there are several independent sources of enrollment data, small discrepancies among the various tables may exist. See note at beginning of this section.

Update: 1/88

ATTACHMENT B

TABLE E4

MEAN DEBTS OF SENIOR MEDICAL STUDENTS*

Academic Year	All Seniors	Seniors with Debt	With Debt % of Seniors
1978-79**	$ 11,045 (n=7701)	$ 14,622 (n=5817)	74
1979-80**	$ 12,690 (n=9669)	$ 16,490 (n=7441)	77
1980-81	$ 15,167 (n=8148)	$ 19,697 (n=6274)	77
1981-82	$ 17,462 (n=10,498)	$ 21,051 (n=8703)	83
1982-83	$ 20,389 (n=10,073)	$ 23,647 (n=8683)	86
1983-84***	$ 23,347 (n=8041)	$ 26,496 (n=6903)	88
1984-85	$ 25,938 (n=10,844)	$ 29,943 (n=9104)	87
1985-86	$ 27,493 (n=10,623)	$ 33,499 (n=8494)	82
1986-87	$ 29,289 (n=11,184)	$ 35,621 (n=8961)	82

* Includes both pre-medical and medical school debt, excludes spouse's debt.

** Data for 1978-80 are not comparable to data collected after 1980.

*** Due to an error in survery instructions, data for this year may be subject to a slight downward bias.

Source: Graduation Questionnaire

Update: 1/88

ATTACHMENT C

TABLE B4

SELECTED MINORITY GROUP TOTAL ENROLLMENT IN U.S. MEDICAL SCHOOLS

Year	Black American		American Indian		Mexican American		Mainland Puerto Rican		
	Number Enrolled+	% of Total Enrollment	Number Enrolled	% of Total Enrollment	Number Enrolled	% of Total Enrollment	Number Enrolled	% of Total Enrollment	Total Enrollment
1968-69	783	2.2	9	*	59	0.2	3	*	35,833
1969-70	1,042	2.8	18	*	92	0.2	26	*	37,669
1970-71	1,509	3.8	18	*	148	0.4	48	0.1	40,487
1971-72	2,055	4.7	42	0.1	252	0.6	76	0.2	43,650
1972-73	2,582	5.5	69	0.2	361	0.8	90	0.2	47,366
1973-74	3,049	6.0	97	0.2	496	1.0	123	0.2	50,751
1974-75	3,355	6.3	159	0.3	638	1.2	172	0.3	53,554
1975-76	3,456	6.2	172	0.3	699	1.3	197	0.4	55,818
1976-77	3,517	6.1	186	0.3	780	1.4	232	0.4	57,765
1977-78	3,587	6.0	201	0.3	831	1.4	261	0.4	60,039
1978-79	3,537	5.7	202	0.3	882	1.4	277	0.4	62,213
1979-80	3,627	5.7	212	0.3	964	1.5	283	0.4	63,800#
1980-81	3,708	5.7	221	0.3	951	1.5	329	0.5	65,189~
1981-82	3,884	5.9	229	0.3	1,040	1.6	350	0.5	66,298
1982-83	3,869	5.8	235	0.4	1,071	1.6	369	0.6	66,748
1983-84	3,892	5.8	258	0.4	1,082	1.6	368	0.5	67,327
1984-85	3,944	5.9	257	0.4	1,126	1.7	380	0.6	67,016
1985-86	3,849	5.8	235	0.4	1,143	1.7	428	0.6	66,585
1986-87	3,892	5.9	242	0.4	1,153	1.7	435	0.7	66,125
1987-88	3,968	6.0	233	0.4	1,144	1.7	467	0.7	65,735

+These figures include Black Americans enrolled at predominantly Black schools. In 1987-88, 613 were enrolled at Howard, Meharry, and Morehouse Medical Schools.

*Less than 0.1 percent.

#Total includes 22 students from whom data were not available.

~Total includes 55 students from whom data were not available.

Note: U.S. Citizens redefined in 1981 to include students with permanent resident visa.

Source: AAMC Section for Student Services (Fall Enrollment Questionnaire).

Update: 11/87

Senator **Matsunaga**. Thank you very much, Dr. Samuelson.

In your testimony, you advocate higher funding levels for nearly all programs under Title VII, especially for primary care residency programs and student assistance.

The question constantly raised by those who advocate what you advocate is this: Why should Congress view these as priority areas, especially in light of the efforts to control Federal spending and reduce the Federal budget?

Dr. **Samuelson**. Well, that is a difficult question, obviously. We believe that often we are looking at not only the needs of the students, which we think are important and honorable, but access to care for the people of our Nation.

It is those who are particularly disadvantaged and having problems with access already who are dependent on the need for more primary care physicians. If we do not provide support for those who will render primary and to those who are in disadvantaged and minority situations, we are concerned that the health of the Nation is at peril.

Senator **Matsunaga**. In your written testimony, you also mention the need to include a loan forgiveness provision for physicians pursuing academic careers. Why should the Federal Government provide funds to facilitate physicians choosing careers in academic medicine?

Dr. **Samuelson**. Well, we believe that it is important to have a very solid corps of excellent teachers and particularly researchers. One of the things that makes us most proud of American medicine is the pushing back of the frontiers of knowledge that have allowed us to have better understanding of disease processes and disease prevention. Because the problems of research careers particularly are so limited, we believe that efforts to recruit excellent young people into research/academic careers could be enhanced by forgiveness of loans in very specific and narrow situations.

Senator **Matsunaga**. How has the problem of increasing student indebtedness affect students at the University of Utah?

Dr. **Samuelson**. Well, we are not sure. One of the questions that we are always asking is does the increased indebtedness distort or alter the specialty choice that the students make.

We have not been able to find evidence that that is the case at Utah, nor do I believe that that is so nationally, although we are looking at it very carefully.

The one thing that does seem to affect specialty choice is the specter of working conditions for those in primary care, and we are concerned that primary care has been viewed as less attractive for a large number of other reasons in addition to the indebtedness.

Senator **Matsunaga**. Well, thank you very much, Dr. Samuelson.

Now we will be happy to hear from you, Dr. Wotman.

Dr. **Wotman**. Thank you, Mr. Chairman.

My name is Stephen Wotman. I am the Dean of the School of Dentistry at Case Western Reserve University. I have just come there in the last year, and before that I served as both Acting Dean and Dean for Academic Affairs at the School of Public Health of Columbia University.

I am very much in agreement with the comments made by Dr. Samuelson concerning student loans, and that is in our written testimony. I would like, however, to emphasize here our concerns about the general dentistry residencies, the geriatrics programs, and the AIDS provisions of this bill; as a representative of the American Association of Dental Schools, I hope this will be helpful.

First of all, the general dentistry residences are the equivalent of an internship, (a medical internship) not for physicians, but for dentists, these provide the opportunity to encourage general dentistry, and to avoid overspecialization in dentistry. Dentists with this type of training provide more comprehensive services; they refer less; they are more comfortable with the more complex problems of compromised patients—the elderly, the handicapped, the chronically ill; other populations at risk who are very much in mind now in terms of dental care.

These programs have high start-up costs; they need to provide ongoing revenue in order to be sustained; they function with a poor patient base, that is, in hospitals and dental schools; and their financing has been eroded by the new reimbursement mechanisms for hospitals and cutbacks in Medicaid.

In the State of Ohio, interestingly, our distribution of General Dentistry programs is very similar to that you heard for South Carolina from Senator Thurmond; we have four programs. At Case Western, we are starting up one this summer in which we will have two residents with no Federal funds. There is one at Ohio State University which has 13 residents, two in Youngstown which have 6 residents, and one at Metropolitan General Hospital, a county hospital in Cleveland, which has 8 residents.

The funding authorization now requests $3.3 million for this program. We propose a 15 percent set-aside, which comes closer to the $10 million a year that is needed. At a $41 million appropriation, this would equal $6.15 million for general dentistry.

In the geriatrics program, our concern is a growing population at risk for dental disease. In Cleveland, we have a Geriatric Education Center, which is I think a good example of what this program can do. This is a truly interdisciplinary program. Dentistry, nursing and medicine provide a regional resource this Geriatric education center also involves disciplines such as clinical psychology, allied health (especially speech and hearing), and social work.

The Geriatric Training portion of the bill is new and is yet untested. We know that there are only 30 dentists in the United States who are specially trained in geriatrics. We feel that we need 75 a year over the next several years to be able to provide enough well-trained dentists in geriatrics to meet the needs of the population and train general dentists in geriatric problems. This bill provides about 34 a year, not quite half. We support the proposed levels of authorization for the geriatrics section, but it really needs more funds. This is the largest population at-risk-for dental disease that we know of.

As far as AIDS is concerned, it is clear that emphasis is required on education about AIDS for practicing dentists, for faculty and dental students, and we know the Senate is addressing those issues.

It is not so apparent, though, that AIDS has caused an $11 million increase in the cost of doing business for dental schools. This is because every dental school has had to intensify its infection control measures, and it costs about one dollar per patient visit in order to finance these efforts. We propose that a per-patient reimbursement be considered by the Senate and that this be included in this bill. Otherwise, the cost falls on the patients in the dental schools and the students in the dental schools, people who can least afford to subsidize this.

To recap this presentation, general practice residencies are an essential area for dentistry. One out of every three students who are applying for general practice residencies cannot find a residency because there are not enough positions. In geriatrics, we support the authorization, and we hope that that can be increased. And for AIDS, we would like, consideration of some patient visit reimbursement to help the dental schools in their efforts to provide care to all patients.

Thank you very much for this opportunity to testify, Senator. It has been a nice trip in today from Cleveland. I would be happy to answer any questions you might have.

[The prepared statement of Dr. Wotman follows:]

AMERICAN
ASSOCIATION
OF DENTAL
SCHOOLS

1625 MASSACHUSETTS AVENUE, N.W.
WASHINGTON, D.C. 20036

202/667-9433

STATEMENT OF THE
AMERICAN ASSOCIATION OF DENTAL SCHOOLS
ON
REAUTHORIZATION OF TITLE VII OF THE PUBLIC HEALTH SERVICE ACT

* * * * * * * *

SUBMITTED FOR THE RECORD ON

APRIL 26, 1988

TO THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

* * * * * * * *

ORAL PRESENTATION BY

STEPHEN WOTMAN, D.D.S.

DEAN

CASE WESTERN RESERVE UNIVERSITY

SCHOOL OF DENTISTRY

APRIL 28, 1988

I am Dr. Stephen Wotman, Dean of the School of Dentistry at Case Western Reserve University in Cleveland, Ohio. Prior to assuming this position, I was Dean for Academic Affairs and Acting Dean of the School of Public Health at Columbia University in New York City. I appear today on behalf of the American Association of Dental Schools.

The American Association of Dental Schools (AADS) represents all of the dental schools in the United States, as well as advanced education, hospital, and allied dental education institutions. Ours is the only national organization concerned exclusively with the needs of dental education.

The AADS is pleased to present this statement expressing our Association's views on the major programs authorized under Title VII of the Public Health Service Act. These comments include AADS's review of the reauthorization provisions in Senate Bill 2229.

When discussing training for dental students, the first question asked frequently is: "Aren't there too many dentists?" In fact, an examination of both the supply and demand sides of the equation makes it clear that further reductions of dental enrollments are not in the public interest. Dental schools have responded to demographic and other factors by decreasing their first year enrollments from 6300 to 4370 -- a 31 percent reduction -- in the last ten years. We believe that any oversupply problem that existed in dentistry has now been addressed. The AADS foresees strong demand for certain types of care, particularly among the elderly, the disabled, and those who suffer from Acquired Immunodeficiency Syndrome (AIDS).

While numerous studies have documented the decline in the dental decay rate for children, annual visit rates for children have mostly remained stable or increased. The result has been improved oral health and a lower incidence of untreated disease. However, much work remains to be done to bring the benefits of improved oral health to children in underserved groups, including those in the southern U.S. border areas and those who are disabled or medically compromised.

Older Americans will account for an increasing proportion of the demand for dental services, as Americans live longer and keep their teeth longer. A 1971 NIDR adult dental survey showed that 38 percent of individuals aged 50 to 59 years had lost all their teeth; by 1985 only 19 percent of those age 50 to 59 were edentulous. Morever, persons with teeth visit the dentist roughly three times more frequently than those with no teeth. Thus, as the U.S. population ages and as a higher proportion of older people retain their teeth, the demand for dental care for the elderly is certain to grow.

Currently, federal assistance for health professions education is targeted to achieve specific training goals in the national interest. These federal funds no longer encourage an overall increase in the number of health care professionals. Rather, they support programs that aid in the establishment of geriatric education centers and geriatric training programs, foster the recruitment and retention of minority and disadvantaged students, and establish new primary care training positions -- including General Dentistry residencies.

Our comments fall within three sections: "special care" programs (including primary care, geriatrics, and AIDS); student assistance; and special projects and other authorities (including allied health).

I. "Special Care" Programs

Primary Care, Geriatrics, AIDS

A. General Dentistry Residencies and Advanced Education in General Dentistry programs:

The General Dentistry program was originally created to encourage more dentists to provide primary care services, and to avert an overspecialization problem in dentistry. General Dentistry programs provide dentists with the skills and clinical experience they need to treat elderly patients and other individuals requiring specialized or complex care, such as the handicapped, medically compromised, and those infected with the AIDS virus. An adequate pool of dentists--well-qualified by virtue of having had this additional training--must be available to meet the oral health needs of our nation's changing patient population. In addition, advanced training programs in General Dentistry aid in the difficult transition from pre-doctoral education to general practice, which in today's environment requires that dentists understand the treatment of special patients.

The impact of this training was evaluated in a study completed by the Department of Health and Human Services in November 1981. In comparing those who had completed a General Dentistry residency with dentists lacking this training, the study found that General Dentistry residents were: more productive in performing surgical procedures, more likely to use the medical laboratory, more likely to utilize complex procedures, and less likely to refer patients to specialists. The General Dentistry residents also had more hospital staff appointments, and within the hospital admitted more patients and performed a wider range of services compared to the non-trainee.

The past federal investment in General Dentistry programs has brought demonstrated success. As a result of federal support for General Dentistry residency programs over the past ten years, 32 new programs have been created and 230 new positions were funded. General Dentistry grant funds have supported the establishment of 54 percent of the new non-Federal (non-military or Veterans Administration) programs that have come on-line since 1977, and have been responsible for 60 percent of the increases in first year General Dentistry postdoctoral positions established since the program began ten years ago. Between 1977 and 1987, the percentage of dental school graduates entering General Dentistry residencies increased from 15 percent to 24 percent. Most of the General Dentistry residents have remained in primary care, many in underserved areas.

The demand for training, however, has far outpaced the initiation of new positions. In 1987, approximately one out of every three applicants for dental general practice residency positions was turned away. Additional support is needed to increase the number of training positions.

Since 1978, dental schools have received "seed" money to establish new dental general practice residency programs, and to expand existing programs. Without federal support, it is extremely difficult to create new programs because of the high cost of dental equipment and instrumentation. Programs are expected to become self-sufficient within a three-year "start-up" phase. However, this is also becoming increasingly difficult due to cuts in hospital reimbursement formulas and other economic constraints faced by dental schools and hospitals. Dental programs, unlike their medical counterparts, face additional financial obstacles in establishing or maintaining these programs beyond the three years; dental schools lack reimbursement for dental services through Medicare, and the available Medicaid reimbursement is extremely limited. Even programs that appear to be self-sufficient actually receive added support from the school or hospital, and are not able to increase the number of positions to meet the current student demand.

Hospitals and schools in many states would like to initiate General Dentistry programs, but are not able to do so because federal funds are inadequate. At least 24 states have expressed an interest in establishing new positions through this program; many more have become discouraged from applying, as 57 dental schools and over 500 hospitals were eligible to apply for only $2.6 million in FY 1988.

The AADS requests a significant expansion of this program to more adequately meet the current demand for training. The programs that have been funded in recent years are expanding their reach to offer trainees a wide range of didactic and clinical experiences in a variety of hospital and community settings. This approach exposes trainees to a full mix of patient needs, and affords the opportunity to meet with medical colleagues in an integrated medical and dental care setting.

S. 2229 would authorize $41 million for each fiscal year 1989-91 for family medicine training, with a 7 1/2 percent set-aside for General Dentistry training. This set-aside would increase to 15 percent only for appropriated amounts in excess of $38 million. AADS recommends a more equitable set-aside for General Dentistry. At an appropriation of $41 million, the S. 2229 formula would make available only $3.3 million for General Dentistry. AADS supports a 15 percent set-aside for General Dentistry, applicable to the total amount appropriated; at the full $41 million appropriation, a 15 percent set-aside would allow $6.15 million for General Dentistry and make available $34.85 million for family medicine (up from the current allocation of $32.7 million). Thus, this proposal would not decrease family medicine funding, but would provide a much-needed increase for General Dentistry.

B. Geriatric Initiatives:

1. Geriatric Education Centers: The activities of Geriatric Education Centers (GECs) include short-term faculty training, curriculum and other educational resource development, and technical assistance and outreach. These programs are multi-disciplinary in nature, and are affiliated with other educational institutions, hospitals, nursing homes, community-based centers for the aged, and/or Veterans

Administration hospitals. Many of the GECs provide geriatric evaluation units that serve as centers for clinical training. In addition, health practitioners are provided continuing education, and health professions students rotate through GEC clinics. In FY 1987, 31 GECs nationwide were supported with almost $10 million.

S. 2229 would authorize $10 million for fiscal year 1989, $12 million for fiscal year 1990, and $14 million for fiscal year 1991 for GECs. AADS supports these amounts, which will allow for minimal growth in this high-priority program, but urges the committee to consider higher authorization levels that would come closer to meeting the actual needs for this program.

2. Geriatric Training: Last year, Congress enacted legislation to complement the GEC initiative. This new authority provides that one- and two-year postdoctoral fellowships and one year faculty retraining programs be established to train medical and dental faculty in geriatrics. The fellowships will offer much-needed in-depth geriatrics study to a small number of academicians and researchers.

In FY 1988, $2.7 million was made available for the initiation of these grants for Faculty Training Projects in Geriatric Medicine and Dentistry. The program is expected to support 15 projects that would begin training approximately 45 medical and dental faculty in July, 1989.

The 1987 U.S. Department of Health and Human Services report to Congress, "Personnel for Health Needs of the Elderly Through Year 2020," pointed out the urgent need to begin training a sufficient "leadership cadre" in geriatric dentistry -- approximately 2,000 dentist-geriatricians by the year 2020 -- to teach, conduct research, and be available for specialized consultation. In order to reach this goal, 75 dentists must be trained each year. Today, of the approximately 143,000 practicing dentists in the United States, fewer than thirty have received formal training at that advanced level in geriatrics. At the FY 1988 funding level, approximately 15 dentist-geriatricians will be trained annually. There remains a critical need to increase the number of dental faculty with advanced training in geriatrics.

S. 2229 would authorize $10 million for fiscal year 1989, $12 million for fiscal year 1990, and $14 million for fiscal year 1991 for geriatric training. Twice this authorization would be necessary to meet the recommendations of the Department of Health and Human Services.

C. Acquired Immunodeficiency Syndrome (AIDS):

A number of bills were introduced in Congress last year addressing different aspects of the AIDS problem. Among them are bills that would authorize funds for continuing education on AIDS for health practitioners and for training of health professionals.

Testimony presented before the Presidential Commission on the HIV Epidemic cited the report of a task force on AIDS Health Care Delivery which was chaired by the Administrator of the Health Resources and Services Administration. Included among the task force's findings are "gaps in the education, training and experience of health care professionals in caring for persons with AIDS," and "gaps in financing to cover the specific health needs of AIDS patients." The task force recommends that health professions schools place a greater emphasis on the care of AIDS patients and HIV-infected persons in curricula and training, and that funds be used to support education training centers.

AADS believes that the renewal of the Title VII authorities provides an opportunity to address the need for training health professions students to effectively treat and manage AIDS patients. Health professions institutions have begun to respond by expanding and enhancing AIDS education and training programs for their students, but there is more that can, and must, be done. Dental education institutions, which lack sources of federal reimbursement available to medicine, seek compensation for the increased costs associated with teaching dental students to provide care according to the CDC (Centers for Disease Control) and OSHA (Occupational Safety and Health Administration) infection control guidelines.

Health professions students must treat all patients as if they were HIV positive, in order to protect their patients and themselves from risk of infection. Dental schools have unique needs in this area. Unlike medical schools, which use hospital settings for teaching the clinical aspects of the profession, dental students usually treat patients in the dental school clinic. Changes in infection control procedures necessary to protect all patients, staff, faculty, and students from infectious disease require the upgrading of clinical sterilization equipment and facilities, the purchase of significant quantities of disposable supplies, and the hiring of additional staff. Proper infection control means that each procedure takes more time and utilizes additional supplies. This translates into significantly greater costs.

Our Association recommends that dental education institutions be compensated for this additional cost by applying a formula based on the number of patient visits to the dental education institution's clinic(s) during the year. Such reimbursement will allow dental education institutions to continue to provide care to patients at reduced fee levels while making the costly adjustments necessary to teach proper infection control.

Dental practitioners can be reached through continuing education programs focusing on AIDS. We believe that these continuing education courses must be federally-subsidized if they are to offer training to health care professionals who might not otherwise have access to information about AIDS and infection control. While some continuing education is occurring through the existing AIDS education training centers program, it must be recognized that all dentists throughout the nation need access to accurate, up-to-date information. At our annual meeting in March, it was noted that reliance on the four regional ETCs (at University of California-Davis, New York University, Ohio State University, and University of Washington-Seattle) will leave many of the country's health professionals without access to continuing education on AIDS. Our members advise that, if we wish to reach practicing dentists with continuing education, it must be available locally.

Currently, our Association is working on a project with the Centers for Disease Control to develop curriculum guidelines that dental education institutions will use to modify their educational programs in light of the AIDS epidemic. Once disseminated, we will need to examine methods to ensure that institutions are able to implement necessary changes in a timely and effective manner.

S. 2229 does not include any provisions to deal with these AIDS-related problems. The AADS recommends that section 402 of S. 1220 be expanded and incorporated within Title VII to establish a grant program for medical and dental schools. This support could fund projects to: train health professions faculty to teach students to provide care and treatment for AIDS patients; implement curricular changes relating to the care of AIDS patients; provide continuing education on AIDS for health professionals; and assist dental schools in renovating their equipment and facilities, purchasing supplies and hiring additional staff necessary to respond to the AIDS crisis.

II. Student Assistance

A. Health Education Assistance Loans (HEAL):

This program was established as a loan "of last resort", providing borrowing at market rate for health professions students who have no other means to finance the costs of their professional education. The program has grown significantly since its creation in 1979, and HEAL loans now comprise a major portion of the average dental student's total indebtedness. Because of the size of the program and its importance to our students, the AADS has comments on several HEAL issues in this statement.

1. Credit Authority: This program requires no federal expenditure but provides a federal guarantee to loans made by private lenders. Credit ceiling authorizations for the HEAL program should be increased to levels that will assure adequate

access to health professions students. $350 million is expected to be borrowed in FY 1988. The credit ceiling increases we support, together with the "carry-over" from each of the prior fiscal years, would result in a modest annual increase in credit authority of $25 million for each of the next three years. Since the inception of the HEAL program in 1979, over 13,000 dental students have borrowed approximately $239 million. Without HEAL loans, many of these students would be forced to discontinue their training.

S. 2229 authorizes loan insurance limits of $325 million in FY 1989, $375 million in FY 1990, and $425 million in FY 1991, and provides that unused credit can be carried over from year to year. AADS supports these authorization levels and the carry-over provision.

2. Apportionment: Apportionment is the administrative process of releasing Federal funds as they are needed to meet government obligations. While this process allows the timely use of Federal money for many government programs, it is inappropriate to apply this budgetary technique to the HEAL program. HEAL loans are federally guaranteed, but are made with private capital.

The apportionment process--when applied to the HEAL program--only impedes the ability of lenders to make loans available in a smooth and timely manner, restricts the availability of HEAL loans to needy students, and does not result in savings for the federal government. S. 2229 would make loan insurance available without regard to apportionment; AADS supports this provision.

3. Eligibility:

a. Post-doctoral students- Many dental residents pay tuition or receive no stipend for their postdoctoral training. While we would prefer to be in a position to offer adequate stipends to all postdoctoral residents, economic realities make that an impossibility for a growing number of programs. Our Advisory Committee on Financial Aid recommends that postdoctoral students be allowed to borrow under the HEAL program to defray the costs they incur in completing their education. To limit student indebtedness, we recommend that the yearly and cumulative borrowing limits not be changed, thereby giving postdoctoral students access to HEAL loans only to the extent that they do not exhaust their HEAL borrowing in dental school.

S. 2229 does not include such a provision. Section 731 limits HEAL eligibility to full-time students as defined in section 770 (c) (2). AADS recommends adding language to this later section to include health professions school graduates receiving training of at least one year at a hospital or health care facility, leading to a degree or certificate.

b. Allied Health- By the elimination of paragraph (4) of section 737 (defining an allied health program as master's or doctoral level work), S. 2229 would permit bachelor's degree students in allied health to borrow under HEAL. AADS does not believe such an expansion is warranted, since current HEAL insurance limits are just adequate to cover the borrowing needs of graduate health professions students. Also, AADS does not believe it is good student financial aid policy to offer unsubsidized, market-rate loans (where interest accrues during the in-school period) to undergraduate students; accumulation of such a debt at the undergraduate level may lead to high defaults and discourage further advanced training.

4. Loan Repayment: Because of rising indebtedness levels, many health professions graduates must choose careers with incomes high enough to allow them to repay their student loans. As a result, academic and research positions have become less attractive. Section 735 (c)(1) of Title VII currently authorizes loan repayment in exchange for commitments to practice in underserved areas. Expansion of this program, to provide loan repayment for graduates who accept positions in education or research fields, is critically needed to maintain the quality of our nation's health professions education and research enterprise.

S. 2229 does not include such a provision. The AADS recommends that existing authority for loan repayment in section 735 should be expanded to allow for repayment of HEAL loans to students with high debts who opt for low-paying research or teaching careers, as well as those who practice in underserved areas. We recommend that "such sums as may be necessary" be authorized for each year.

5. Default Prevention:

a. Administrative Solutions- The AADS shares Congress's concern about the default problem in the HEAL program, and has worked with the Department of Education, lenders, and schools on improving collections of defaulted claims. In the most recent reauthorization of the HEAL program, many new due diligence procedures were identified that were incorporated in regulations issued last year. However, we believe that more can be done to improve the administration of this program and reduce the default rate.

The HEAL program operations report for the period ending September 30, 1987 includes $24.5 million dollars--over half of the default claims made--in categories such as "to be referred to the Department of Justice", "in negotiation", and "to be referred to collection agencies". Many of these claims could be brought into repayment with additional personnel and improved due diligence.

The AADS recommends that the Department of Health and Human Services be directed to make every effort to assure that an adequate number of qualified personnel is available to track HEAL claims and conduct proper due diligence procedures.

b. Discharges in Bankruptcy- The FY 1987 HEAL program operations report (Table 8) categorizes 207 claims, totaling over $4.8 million, as "bankruptcies in claims". It is unfortunate that some judges interpret the law to allow cancellation of HEAL loans through bankruptcy, despite language in Section 733 that restricts such discharges only to situations where five years have passed since repayment began and non-discharge would be unconscionable. Although these decisions are reversed on appeal to higher courts, much time and expense is involved in the process.

S. 2229 clarifies that HEAL loans may not be discharged in a bankruptcy claim, under any Chapter of Title 11 of the United States Code, for five years after the loan enters repayment. **AADS supports this provision.**

c. Default Calculation- While the AADS is encouraged by all the efforts being made to address the default problem, we have serious concerns about the formula DHHS uses to calculate defaults for the HEAL program. In the program operations report cited above, $16.7 million or 35% of the total claims reported are now either in repayment, forbearance, or deferment status.

For dentistry, the gross claims rate was 10.61% of borrowers and 10.75% of dollars in FY 1985. By FY 1987, the borrower rate had dropped to 8.7%, while the dollar rate increased very slightly to 11%. These rates, however, continue to count as defaults loans that subsequently come into repayment. For the past two years, dental schools have had the highest repayment rate of all health professions. Currently, 35% of all HEAL claims paid on behalf of dental students are back in repayment.

The AADS strongly advocates that a definition of "net" defaults be included in S. 2229, which will take into account defaulted claims that have subsequently entered repayment.

d. Litigation- The responsibility for due diligence, including the use of litigation where appropriate, should apply to all HEAL lenders. A regulation extending the litigation requirement to the Student Loan Marketing Association (Sallie Mae), which is now not required to litigate, is currently being processed through DHHS. The obligation to litigate should be required of all lenders as a condition of eligibility.

6. Need Analysis: In an attempt to limit unnecessary HEAL borrowing, DHHS issued final regulations last year that place increased emphasis on schools' need to closely evaluate students' actual resources and expenses before approving HEAL loans. While we agree with this strategy, we are concerned that recent changes

to the need analysis system used by the Department of Education (and referenced in the HEAL regulation) could negatively impact health professions students attempting to borrow HEAL loans. To assure borrowing eligibility for students who truly need HEAL loans, the AADS recommends that the flexibility financial aid officers now have under uniform methodology in calculating health professions students' budgets (for purposes of determining need for the HEAL program) be maintained.

7. Compounding of Interest and Statute of Limitations: S.2229 amends section 731 (a)(2)(D) to allow lenders to compound interest on HEAL loans less frequently than semiannually, and amends section 733 to provide for a uniform 6 year statute of limitations on debt actions. AADS supports these provisions.

B. Health Professions Student Loans (HPSL):

Unlike HEAL, the HPSL program is administered entirely by health professions schools. Money is loaned from revolving funds that were established with federal capital and an institutional contribution. The schools are responsible for diligent collection of loans in repayment, and have flexibility in allocating available funds based on students' varying circumstances. The HPSL program is a relatively low-interest rate loan available to needy health professions students who have few alternatives to borrowing to pay their educational expenses. The program has not received any new federal capital contribution since FY 1983 when it received $1 million.

1. Needs Analysis: In 1987, dental students had an average level of indebtedness of $39,200. The average amount borrowed from HPSL was $3,280, far below the statutory maximum. Although HPSL represents a small percentage of students' overall indebtedness, it plays an important role in health professions students' financing. Imposition of a strict HPSL needs test helps to allocate limited funds to the most needy students. While the AADS understands and supports the use of a need analysis system, we believe that financial aid officers--who often are in the best position to judge a student's financial situation--should be granted flexibility to exercise their professional judgment in assessing individual circumstances. For example, it is sometimes entirely inappropriate to require parental tax forms from adult students.

The Association recommends that a provision be included in the S. 2229 HPSL section allowing financial aid officers to exercise "professional judgment" in determining financial need of students with unusual circumstances, provided they are able to appropriately document the reasons behind their decisions.

2. Defaults: The HPSL program was the subject of Congressional hearings in 1981 due to high delinquency rates, averaging 12% for

health professions schools participating in the program. Since that time, the Department of Health and Human Services and participating schools have taken forceful steps to strengthen the administration of the HPSL program. Due to these cooperative efforts involving improved due diligence procedures, the cumulative rate--meaning delinquent accounts tallied since the inception of the program--is now 2.6% for all professions. Dental schools have lowered their average delinquency rate from 11% in 1981 to 2.8% as of June 30, 1987. These decreases illustrate the institutional commitment to strong and efficient management of the HPSL program.

3. Eligibility and Authorization: Under S. 2229 students in graduate programs in clinical psychology and allied health would be eligible to borrow under the HPSL program. AADS opposes this expansion in eligibility unless the federal capital contribution amounts ($15 million in FY 1989, $16 million in FY 1990, and $17 million in FY 1991) are increased to accomodate the substantial additional need such an expansion would generate.

S. 2229 also eliminates section 742 (b)(5), thereby allowing all schools, regardless of when they entered the program, to be eligible to receive new funds. AADS supports this provision.

4. Loan Repayment: S. 2229 extends section 741 -- that provides for repayment of loans if an individual agrees to serve in a

health manpower shortage area -- to cover service as a full-time faculty member not receiving a fellowship or stipend. AADS strongly supports this change, which would provide recent graduates an opportunity to accept a low-paying faculty position despite significant student debt burdens.

C. Exceptional Financial Need Scholarships:

The Exceptional Financial Need program provides scholarships for first-year students with no financial resources. This program was established so that economically disadvantaged individuals, regardless of their educational abilities, would not be forced to assume high levels of debt in order to pursue a health professions career. The EFN program currently provides full funding of educational costs for one year only.

In FY 1987, $6.9 million was awarded to 405 first year health professions students, an amount which falls far short of the need for this program by students with zero financial resources. Last year over $21 million would have been required to award funds to all 1,319 students who qualified.

Because the funding for this program is so limited, some schools would find it advantageous to allocate a scholarship among more than one exceptionally financially needy student. This is not possible under current law.

S. 2229 authorizes $20 million for each fiscal year from 1989 to 1991, and would modify section 758 (b) to allow coverage of all or part of tuition. AADS supports these provisions.

D. Financial Assistance for Disadvantaged Health Professions Students (FADHPS):

This recently-established program is available to medical, osteopathic, and dental students in any year of study. Institutions receive awards based on the total number of eligible students, and may award the grants to these needy students as their individual circumstances indicate. Although the amount awarded last year was only a fraction of the $37.2 million needed by financially disadvantaged students, the program meets a critical need by providing grant assistance for disadvantaged health professions students beyond their first year. In FY 1987 only $5.4 million was awarded for this important effort.

S. 2229 would not reauthorize FADHPS; the 20 percent set-aside would instead go to student stipends for HCOP student summer enrichment programs. While AADS supports funding for HCOP sufficient to allow summer programs for students prior to their entry into health professions schools, we also recommended $10 million per fiscal year for FADHPS. AADS believes that the current stipend program complements HCOP recruitment and retention initiatives by insuring that qualified disadvantaged students are able to attend health professions schools.

E. Health Careers Opportunity Program (HCOP) grants:

The Health Careers Opportunity Program is the primary program supported by the federal government to recruit underrepresented minorities into health professions schools, to assist them in preparing to enter these schools, and to retain them once they are admitted. Despite some success, significant underrepresentation still exists. This in turn has created serious problems in the delivery of health care to our nation's Black and Hispanic citizens, which will be exacerbated without continued and increased federal support of the HCOP program.

S. 2229 would authorize $30 million in FY 1989, $32 million in FY 1990, and $34 million in FY 1991 for HCOP. There would be new requirements for institutional participation: schools would have to increase their enrollment of disadvantaged students by 20 percent within 3 years, or face ineligibility until this condition is met. This requirement is applicable to schools whose disadvantaged enrollment figure is less than double the national average for total enrollment of such individuals in health professions programs. AADS supports this section; however, we urge the Committee not to terminate the FADHPS program.

As a member of the Federation of Associations of Schools of the Health Professions, AADS has recommended that this reauthorization provide for the conduct of an independent evaluative study of HCOP to measure past results, identify successsful strategies, define model programs, and promote their use by all health professions schools in their efforts to recruit and retain disadvantaged students. AADS supports such an addition to S. 2229.

A related problem faced by most dental schools is the lack of faculty from underrepresented minorities. Black faculty, for example, currently comprise only 3.9% of the total (full- and part-time) dental school faculty. Of these, 55% are at Meharry and Howard dental schools.

We urge Congress to support demonstration projects to recruit and retain minority faculty and administrators. Interested young dentists and other health professionals could be identified and trained in the skills needed for academic and research careers. A modest investment would allow experimentation with two or three approaches to the recruitment and retention of minority faculty. AADS recommends that at least $1 million be provided each year in S. 2229 for demonstration projects concerning the recruitment and retention of minority faculty.

III. Special Projects and Other Authorities

Special Initiatives:

The Health Professions Educational Assistance Act includes authority to fund "special initiatives" in areas such as curriculum and faculty development. The program is currently funded at $2.5 Million, however, most of that amount goes to only two projects.

The AADS believes there is a compelling need for a basic educational research grant program that would fund innovative programs in faculty and curriculum development, and in new areas such as computer training programs or development of alternative care sites. Individual schools simply do not have the resources to respond to all the social, economic, and technological changes that place increased demands upon health professions education. A modest federal investment in funding special projects could result in cost-saving initiatives having applications in other areas of health care, or in innovative techniques in teaching or practice. Competition would occur within each health professions discipline, and each profession would receive a share of the funding. Investigator-initiated projects should be encouraged. Funding priorities would be determined by the Secretary of DHHS upon consultation with the health professions schools and the National Advisory Council on the Health Professions.

S. 2229 authorizes $8 million for each FY 1989-91 for several special projects, including grants to health professions schools for faculty and curriculum development and training, and the development of new clinical training sites. AADS recommends that

this authorization be increased by $2 million per year.

Other Authorities:

A. Area Health Education Centers:

Title VII funding also supports Area Health Education Centers (AHECs), which provide multidisciplinary training to health professions students in non-traditional settings. This program is designed to encourage graduates to locate in rural areas and to establish a bridge between the rural practitioner and major health science centers.

While dental caries have declined significantly for children in recent years, dental decay remains a major problem among children along the U.S. - Mexico border. Several factors, including poor nutrition, lack of adequate health care counseling, and absence of fluoride, contribute to the high prevalence of dental problems among children in these areas.

S. 2229 provides for support in maternal and child health services, including oral health screening and treatment, with priorities given to programs for the U.S.- Mexican border area and other frontier areas with a high rate of infant mortality and a low rate of birthweight. The authorization levels would be $20 million in FY 1989, $21 million in FY 1990, and $16 million in FY 1991. AADS supports this provision.

B. Allied Health:

Authority for allied health curriculum and faculty development projects, and for allied health traineeships expired in 1980. As is true for many other disciplines, dentistry is currently facing a shortage of trained allied health personnel. Federal support is needed to recruit dental hygienists and assistants, and strengthen the administration and curriculum of these programs.

S. 2229 provides authorization of funding for allied health programs in four areas: grants for improving administration, curriculum, and recruitment ($4.8 million in FY 1989, $5 million per year for FYs 1990 and 1991); grants for student financial assistance ($4 million for FY 1989, and $5 million per year for FYs 1990 and 1991); grants for student traineeships in doctoral programs ($5 million for FY 1989, $8.5 million for FT 1990, and $11.5 million for FT 1991); and grants for a reporting and data system ($1.2 million for FY 1989, $2 million for FY 1990, and $3 million for FY 1991). AADS supports all of these allied health provisions, and recommends that dental hygiene programs be specifically included in the data reporting system.

Our Association appreciates the opportunity to submit this testimony for your consideration, and would be pleased to respond to any questions.

Senator MATSUNAGA. Thank you very much, Dr. Wotman.

I must say that Senator Metzenbaum had intended to be here to welcome you, but due to other demands—as I said earlier, we need to be at three or four different places all at the same time in this business. So those of you who might be thinking about running for the Senate someday, I think you had better consider that before you do declare.

Dr. WOTMAN. Deans too have their own problems. [Laughter.]

Senator MATSUNAGA. So I do express Senator Metzenbaum's regrets to you.

Dr. WOTMAN. Thank you, Senator.

Senator MATSUNAGA. Now, you testified that dentists who have had a general dentistry residency refer fewer patients to specialists and are better able to serve the elderly, the poor, the handicapped, as well as AIDS patients. Can you provide any specific data to corroborate these assertions for the record?

Dr. WOTMAN. There was a 1981 study by HHS which provided that kind of data, that I am sure the Association can make available to your office.[1]

In addition, there is at least some evidence from one large program in New York, in Brooklyn, which suggests that 92 percent of their residents over an extended period of time have gone into general dentistry and are referring out fewer less patients.

One of the provisions that the Association recommends in this bill is that contract authority be included so that some stronger data can be accumulated for this kind of evaluation.

Senator MATSUNAGA. As a senior citizen myself, I am curious to know what difference, if any, there is between geriatric dentistry and general dentistry.

Dr. WOTMAN. We know that for the technical aspects of geriatric dentistry, there is not a lot of difference. However, as you know, the geriatric population is not a single population. We have many people, as they get older, who have health care problems and who are medically compromised. We have people who are frail as they get older; we have people who are disabled as they get older; we have people who, as they get older, are unable to socialize well, perhaps because of loss of teeth, and this promotes depression, which is a primary concern of the elderly.

There are a number of elements that elderly patients may exhibit that a dentist may not have had experience with. The general practice residency will give them this kind of experience, both in the behavioral concerns of caring for these patients and the technical concerns involving specific and disease problems of the elderly.

Senator MATSUNAGA. Some have argued that we currently have a surplus of dentists. Applicants to dental schools, I am told, have fallen off significantly in recent years, and some schools have even closed down.

Do we really have a surplus of dentists?

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[1] "An Evaluation of Residency Training in the General Practice of Dentistry", prepared for Division of Dentistry, Health Resources Administration, Department of Health and Human Services, by Response Analysis, Princeton, N.J., 1981.

Dr. **Wotman**. Well, that is a very difficult question at this point in time. Our estimate is that we really don't, and I think that it is based on several facts.

One is that the number of entering students in dental schools over the last ten-year period has been reduced from about 6,100-6,200 per year to about 3,800 this year. That is over 40 percent.

The current dentist population ratio is estimated by the American Association of Dental Schools to be somewhere about 58 to 59 per 100,000 in population.

With the falling number of dental graduates, by 1990 there will be less graduates than there will be dentists retiring or dying. In another five- to ten-year period, by the mid-Nineties, it is expected that the dentist population ratio will begin to fall, and if the current trends continue over a 15- to 20-year period, that will be a precipitous fall, perhaps to as low as 48 per 100,000, which would be the lowest level since World War I.

There is some concern that the dental community has fully compensated for the production of dentists over this period of time and, as happens with many areas of our society, we tend to overcompensate, and we may be getting ourselves into problems associated with overcompensation. We have some concern about how we are going to maintain and improve the oral health of the society through this period.

Senator **Matsunaga**. Well, thank you very much, Dr. Samuelson, Dr. Wotman. We appreciate your taking the time out of your busy day to be here with us.

Thank you very much.

Dr. **Samuelson**. Thank you, Senator.

Dr. **Wotman**. Thank you, Senator.

Senator **Matsunaga**. Our final panel of witnesses consists of Dr. Marcellus Grace, President of the AMHPS, Dean, College of Pharmacy, Xavier University of Louisiana, New Orleans, Louisiana; and Dr. Andrew P. Morley, Jr., Chairman of the Board of Directors, American Academy of Family Physicians, from Kansas City, Missouri.

We certainly appreciate your taking the time to be with us, and we would be happy to hear from you now, Dr. Grace.

STATEMENTS OF DR. MARCELLUS GRACE, PRESIDENT, ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS, AND DEAN, COLLEGE OF PHARMACY, XAVIER UNIVERSITY OF LOUISIANA, NEW ORLEANS, LA; AND DR. ANDREW P. MORLEY, JR., CHAIRMAN, BOARD OF DIRECTORS, AMERICAN ACADEMY OF FAMILY PHYSICIANS, KANSAS CITY, MO

Dr. **Grace**. Thank you, Mr. Chairman.

My name is Marcellus Grace, and I am President of the Association of Minority Health Professions Schools. That is what "AMHPS" stands for.

I would also like to mention that I am a member of the National Association of Minority Medical Educators, better-known as "NAMME", and they are also in support of my statement this afternoon.

The eight institutions represented by our Association have graduated 40 percent of the Nation's black physicians and dentists, some 50 percent of the Nation's black pharmacists, and 75 percent of the Nation's black veterinarians.

We consider these institutions a national resource that have produced a special product, vital to the country in many ways. Many programs contained in this Act profoundly affect the educational missions and success of our institutions, and our collective and individual goals to increase the number of black and other minority health professionals in the Nation.

The institutions represented by the Association, as well as our students, rely heavily on this Federal support. The gains made in the black enrollment and graduates in health professions education programs peaked in the mid-Seventies. In recent years, the applicant pool of blacks and other minorities who seek health professions careers has declined significantly.

Major factors that have led to the decline are: first, the continued lack of education preparedness of these groups; second, the attraction of these young students to other less rigorous and more financially rewarding professions; third, large debts incurred while training and the substantial debt burden facing minorities who pursue health professions careers. For example, the average debt in 1987 of a student graduating from The Morehouse School of Medicine in Atlanta was $49,000 compared to $32,000 just two years ago. This does not include any debt incurred during their undergraduate education. These numbers are staggering to all of us. The fourth reason is the lack of knowledge of and access to potential financial resources to pursue a medical career.

Health professions programs under the Health Personnel and Manpower Training Assistance Act have had a tremendous impact on Federal efforts to supply the Nation with qualified health professionals. However, minority health professionals in disciplines of medicine, dentistry, pharmacy and veterinary medicine continue to experience severe shortages.

While blacks represent approximately 12 percent of the U.S. population, only about 2 to 3 percent serve in these health professions. Also, it is well-documented that while black health professionals serve all races, they are more likely to establish practices or serve in areas with high percentages of minorities. Many of these areas are also health manpower shortage areas identified by the Federal Government. So enhancing the number of minorities in the health professions is a good investment in many respects.

Mr. Chairman, unless health professions programs are adequately maintained and expanded, the numbers of minorities participating in the health professions will remain precariously low. However, as suggested by Secretary Heckler's Task Force Report, the health status of minorities will most likely improve with any increase in the number of minority health professionals.

At this time, Mr. Chairman, let me personally thank on behalf of the Association the support for the Excellence in Minority Health Education and Care Act that made its way through Congress, and the deadline for grants is next Wednesday. The four institutions authorized to participate in this program should be receiving grants for the first time, we are told, about August 1. Once these programs are underway, our Association would support the participation of other select schools in this important initiative.

I would like to take a moment to specifically comment on the HCOP program. It seems that that is very popular today. The Health Careers Opportunity Program, better-known as HCOP, is a valuable resource in our ability to identify, recruit, retrain and train minority health professionals. In fiscal year 1987, 94 HCOP programs were funded that have been helpful in maintaining or increasing minority enrollment in many health professional schools.

One example of a very successful program is at my own institution, and in my written testimony there is a graph that shows that in 1975, we put about 55 students into MODVOPP schools and in 1987, we placed some 100 students into MODVOPP schools.

Recently, the HCOP program has been the subject of questions regarding its effectiveness in carrying out the goal of recruiting and retaining disadvantaged students. Because of this, we do recommend that the reauthorization contain a component that would mandate an evaluation of the program's effectiveness. As well, our Association is very supportive of the performance requirement to increase enrollment of minority students, within a grant period to be eligible to continue receiving grants. We hope this will ensure that more majority schools will increase their commitment to minority enrollment.

I would like to again thank you for allowing me to present the views of both NAMME and the Association of Minority Health Professions Schools today.

[The prepared statement of Dr. Grace follows:]

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TESTIMONY OF

MARCELLUS GRACE, PH.D.
DEAN
XAVIER UNIVERSITY COLLEGE OF PHARMACY

on behalf of

THE ASSOCIATION OF MINORITY HEALTH PROFESSIONS SCHOOLS

concerning

REAUTHORIZATION OF THE HEALTH PERSONNEL
and
MANPOWER TRAINING ACT

presented on

April 28, 1988

Mr. Chairman and Members of the Committee:

Thank you for the opportunity to present the views of the Association of Minority Health Professions Schools regarding the reauthorization of the Health Personnel and Manpower Training Assistance Act.

The member institutions of our Association--the Morehouse School of Medicine, Tuskegee University School of Veterinary Medicine, Xavier University of Louisiana College of Pharmacy, Florida A&M University College of Pharmacy, Texas Southern University College of Pharmacy and Health Sciences, Charles R. Drew Postgraduate Medical School and the Meharry Medical and Dental Colleges -- all have a vital interest in the programs authorized by this Act. The eight institutions represented by our Association have graduated 40 percent of the nation's black physicians and dentists, 50 percent of the nation's black pharmacists, and 75 percent of the nation's black veterinarians. We consider these institutions a national resource that have produced a special product, vital to the country in many ways. Many programs contained in this Act profoundly affect the educational missions and success of our institutions, and our collective and individual goals to increase the number of black and other minority health professionals in the nation. The institutions represented by the Association, as well as our students, rely heavily upon this Federal support.

Shortages of Minorities in the Health Professions

The gains made in black enrollment and graduates in health professions education programs peaked in the mid-seventies. In recent years the applicant pool of blacks and other minorities who seek health professions careers has declined significantly. Four major factors that have led to the decline are (1) the continued lack of educational preparedness of these groups; (2) the attraction of these young students to other less rigorous, and more financially rewarding professions; (3) large debts incurred while training and the substantial debt burden facing minorities who pursue health professions careers. For example, the average debt in 1987 of a student graduating from the Morehouse School of Medicine is $49,000, compared to $32,000 just two years ago. This does not include any debt incurred during undergraduate education. These numbers are staggering to all of us -- but just imagine what they look like to a poor black kid from rural Georgia, and; (4) lack of knowledge of and access to potential financial resources to pursue a medical career.

The attrition rate of minorities in health professions schools has also been identified as a major problem. Comparatively, the retention rate of minorities is much lower than that of non-minorities. The reasons for this are not fully known, but is clear that it is very important to keep these students enrolled once they are in school, given the already significant investment made in the nurturing of these students.

Health professions programs under the Health Personnel and Manpower Training Assistance Act have had a tremendous impact on federal efforts to supply the nation with qualified health professionals. However, minority health professionals in disciplines of medicine, dentistry, pharmacy, and veterinary medicine continue to experience severe shortages. While blacks represent approximately 12 percent of the U.S. population, only about 2-3 percent serve in these health professions.

Also, it is well documented that while black health professionals serve all races, they are more likely to establish practices or serve in areas with high percentages of minorities. Many of these areas are also health manpower shortage areas, identified by the Federal government, so enhancing the number of minorities in the health professions is a good investment in many respects.

Mr. Chairman, unless health professions programs are adequately maintained and expanded, the numbers of minorities participating in the health professions will remain precariously low. However, as suggested by the HHS Secretary's Task Force Report on Black and Minority Health, the health status of minorities will most likely improve with any increase in the number of minority health professionals.

Reauthorization of Health Professions Initiatives

The Association of Minority Health Professions Schools is very supportive of the continued existence of the various programs continued in the Health Manpower Training Assistance Act. Many of the programs currently in place, in our view, need to be improved and expanded to allow for accelerated progress in training of minorities in the health professions, and for institutional support for schools training greater numbers of minorities.

At this time Mr. Chairman, please allow me to express the appreciation of our Association for the action your Committee took last year to approve the Excellence in Minority Health Education and Care Act. The four institutions authorized to participate in this program should be receiving grants for the first time this summer. Once these programs are underway, our Association would support the participation of other select schools in this important initiative.

Health Education Assistance Loans

HEAL loans are an important component of the overall health professions authority, yet they often carry a prohibitive interest rate that discourages an individual, especially a poor minority, from seeking a health professions career. We would like to recommend that the interest rates on HEAL loans be reduced to encourage more minority and disadvantaged use of this mechanism.

Health Professions Student Loans

Funds should be authorized for the Health Professions Student Loan program at a level of approximately $20 million per year. This would allow the continued building of revolving funds, especially at newer health professions schools such as Morehouse, that did not have adequate resources put into these revolving funds before 1984 when the last funds were authorized.

Exceptional Financial Need

Our Association recommends that a greater level of resources be provided for the EFN program, to assist more students, and to allow EFN funds to be utilized for all health professions students in any year of their education. Also, because many of our students are of exceptional need, it would be very helpful if there were greater flexibility in the distribution of funds so that more students could receive some funds at less than the full scholarship level. Flexibility in our ability to distribute funds would allow us to help more students. EFN resources are among the most critical in our institutional ability to offer a bright student a promising educational opportunity.

Health Careers Opportunity Program

The Health Careers Opportunity Program (H-COP) is a valuable resource in our ability to identify, recruit, retain and train minority health professionals. In fiscal year 1987, ninety-four H-COP programs were funded that have been helpful in maintaining or increasing minority enrollment in many health professions schools. An example of a few successful H-COP funded programs are:

1) "Stress on Analytical Reasoning" (SOAR) at Xavier University of Louisiana College of Pharmacy. This program has been highly responsible in ranking Xavier as the nation's number two university placing Black students into medical and dental schools; and the College of Pharmacy is ranked number one in total numbers of Blacks studying pharmacy.

2) The University of Illinois H-COP Program brings high school students into the University for classes in math, science and language skills to prepare them for and interest them in health professions education. The retention rate at this University is a phenomenal 88% - due to continued counseling and tutorial services.

3) The Minority Health Careers Program at Pennsylvania State University has been very successful, with 10% of the undergraduate students now being minority. This school offers three summer programs: The Minority Advanced Placement Program (MAPP) for academically-talented minority students in high school; the Minority Health Careers

Institute (MHCI) is for highly motivated high school students whose grade point averages are not as competitive as those of MAPP students and; the Graduate Minority Health Careers Institute (Graduate MHCI) for academically talented minority students in college.

During the past decade some gains have been made in increasing the enrollments of students of racial/ethnic minority backgrounds in health professions schools. Currently the representation of minority students in these schools ranges from 6% in schools of veterinary medicine to 20% in schools of dentistry, and pharmacy. This compared with a range of 4% (osteopathic medical school) to 12% (allopathic medical schools) a decade ago. However, even these modest gains have not been uniform across all racial/ethnic groups, and for some groups the percentages that they constitute of the total student bodies remain comparatively small. For example, while the percentages of Asians enrolled in these schools doubled or tripled during the past decade, the percentage of American Indians (who historically have comprised less that 1% of total enrollment) have remained approximately the same over this period. Similarly, the representation of black students in these schools currently ranges from 2% in schools of veterinary medicine to 9% in schools of pharmacy -- not substantially different from their status a decade ago when they ranged from 2% of all students in optometry and osteopathic medical schools to 6% in allopathic medical schools. Although the overall gains among Hispanics have been somewhat greater than those among blacks and American Indians, they have not matched those of Asians and their current representation ranges from less than 1% in veterinary medical schools to 4% in dental schools. In addition to the slow progress and increasing the underrepresented minorities who matriculate in health professions schools, there continues to be concerns about the comparatively high percentages of such students who do not graduate. For example, in schools of medicine the attrition rate among underrepresented students currently ranges from 7% among Mainland Puerto Ricans to 18% among American Indians. This compares with a rate of only 3% for all students enrolled in medical schools.

The adoption of the 20% student stipend set-aside has, in over view, limited the impact that the H-COP program can have institutionally to increase enrollment and retention in health professions. Rather than spirit this 20% from an existing critical program, we recommend that a distinct program of stipend support be created for all health professions disciplines (not limited to medicine, dentistry, and osteopathy) that would complement the current institutional based H-COP programs.

Recently, the H-COP program has been the subject of questions regarding its effectiveness in carrying out the goal of recruiting and retaining disadvantaged students. Because of this we recommend that the reauthorization contain a component that would mandate an evaluation of the program's effectiveness. As well, our Association is very supportive of the performance requirement to increase enrollment of minority students during a grant period to be eligible to continue receiving grants. We hope this will insure that more majority schools increase their commitment to minority enrollment.

Area Health Education Centers Program

The AHEC program is designed to increase the number of health practitioners in shortage areas by awarding funds to medical schools that provide training at remote sites that are designated health manpower shortage areas. Our Association supports this important initiative, and recommends that this program be maintained and start-up funds provided for new AHEC programs.

Special Education Initiatives

Within the Special Education Initiatives, the Two-Year Medical School program provides support for the development and enhancement of basic science or clinical medical educational efforts. Our Association recommends continued support for this important initiative and views the participation of all two-year medical schools as an important priority.

Health Professions Minority Initiatives

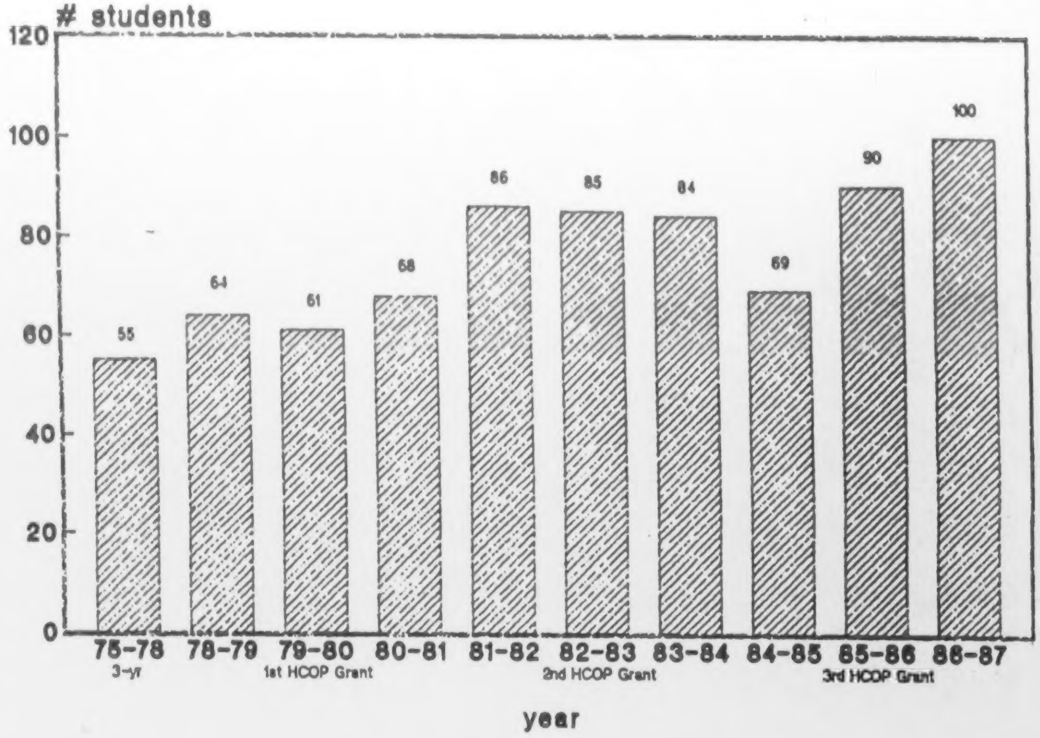
Mr. Chairman, we understand that Senator Kennedy is preparing to introduce a measure that would establish several specific initiatives to improve minority health by increasing the numbers of minority health professionals to serve populations in underserved areas. This bill will contain four distinct parts. They are:

- Re-establish authorized levels for Health Professions Student Loans and targets them for minorities.
- Establish a grant program to assist schools in providing scholarships to minorities.
- Develop a loan repayment program for minority students who agree to accept a faculty assignment at the institution they are attending once training is complete.
- Provide grants to the Office of Minority Health to conduct programs of research, training, education and studies related to adverse health conditions experienced by minority populations.

The Association of Minority Health Professions Schools is very supportive of the Bill being prepared by Senator Kennedy, and urges that your Committee carefully review and consider adding these important components during the Health Manpower Reauthorization.

Mr. Chairman, thank you for the opportunity to appear before you Committee. We deeply appreciate the support you have demonstrated in the past for training minorities in the health professions, and pledge our support for the reauthorization bill.

Xavier University Students
Accepted Into MODVOPP+PH Schools



Senator MATSUNAGA. Thank you, Dr. Grace.

In your testimony you stress the value of the Health Careers Opportunity Program in increasing the number of minorities in the health professions. One of the revisions proposed in S. 2229 would add a performance requirement under this program. How do you think this will impact on the efforts of health profession schools to increase their enrollment of minorities?

Dr. GRACE. Well, we are hopeful—and of course, this may sound counter to the views of my colleague from the AAMC—but we are hopeful that that would motivate majority schools to do their fair share. We represent eight schools, and there is no way possible that we could even attempt to train all the minorities.

The other schools have to do their fair share. Let me pick on the colleges of pharmacy. Last year, there were 18 of our 75 schools that did not have a single black student. I think that is unacceptable. So I suspect, while some of the school programs are excellent, they do have low numbers. Whether it is 10 percent or 20 percent or whatever, there needs to be some motivation for these programs not to get grant moneys and not be motivated to actually have students in the program and get students through those programs.

Senator MATSUNAGA. And can you think of any other way of encouraging an increase in minority enrollment?

Dr. GRACE. I think it has to be a numbers-oriented incentive. In the old days, we had capitation, and we know that that is a dirty word on Capitol Hill now. But certainly, there needs to be some accounting where we can show that those programs indeed are increasing their numbers even if it is from one student to two students the second year, or in the third year have three students. But there are some programs in my own State—and I won't call any names—but there is one major school that has a very small number of minority students, and their grant is larger than the one at Xavier.

Senator MATSUNAGA. Has the decreasing availability of scholarships affected the number of minority students seeking to enter health professions schools?

Dr. GRACE. Yes. And especially at my school, I should add that half of the schools in AMHPS are private schools—the tuition at the Xavier University College of Pharmacy is now $5,800, and for our Pharm.D Program, it is $7,500. Our competitor, the State pharmacy school, is only about $1,500 a year.

About 85 to 90 percent of the students at Xavier are on some type of financial aid, and with, I guess, more restrictions on qualifications by the parents of these students, we are finding more and more of them having to go to the HEAL loan, or as we call it, the loan of last resort. And with the dwindling amounts in the HPSL program, we are finding that for a lot of students, health professional schools are now just out-of-reach, and a lot of students from high school now don't even aspire to be physicians and pharmacists and dentists anymore, and are choosing other professions.

Senator MATSUNAGA. Other than the normal functions performed by medical schools, what is the role of the historically-black health professions schools in training physicians, dentists, pharmacists and other providers in this country?

Dr. **Grace**. I think the major role that we play is having an environment for students to feel comfortable. I am not saying that the minority students will find hostile environments in other schools, but in fact, there have been recent instances, such as the very embarrassing incident with the Ku Klux Klan at The Citadel last year; we had a student at the University of Georgia who was on an externship program last year who made Jet Magazine, actually being told by her preceptor that she had to leave the site because some of the customers came to the pharmacy and complained that he had a black student working in the pharmacy department.

So at our schools, what we have done—in the case of Meharry, for 116 years; in the case of Xavier, for 65 years—we have had an environment that nurtures some students who already have fragile egos, who already have a sense of low value and low self-esteem, as being victims of 200 years of segregation and slavery. Our schools are more caring, and our faculty are more caring in that environment. One study has shown that in fact, students who have the same high school SAT scores do better in a black undergraduate school than the student with a comparable score in a majority school.

We cannot provide the training for everybody who is black or Hispanic or another minority group that would like to become a health professional. But it is important that we survive and that we can do our fair share. Xavier, for example, has trained 25 percent of all the black pharmacists in the United States in my one small school.

Senator **Matsunaga**. Thank you very much, Dr. Grace.

We will be happy now to hear from you, Dr. Morley.

Dr. **Morley**. Thank you, Mr. Chairman.

I am Andy Morley, a family physician from Decatur, Georgia, currently serving as Chairperson of the Board of Directors of the American Academy of Family Physicians. The Academy is the medical specialty society which represents over 60,000 family physicians, residents, and medical students.

I am pleased to appear before this Committee to discuss with you the important role of Federal funds in helping to assure access of quality health care for all Americans. I hope that my testimony will help you in your efforts in Congress to enact legislation reauthorizing support for family practice and other health care professional educational programs of Title VII.

The American Academy of Family Physicians believes that the goal of assuring access to quality health care by all Americans can be met only if there is a supply of appropriate physicians adequate to meet the needs for and the demand for services.

Given the current significant demand for the services of family physicians within this country, the supply is inadequate and will remain so without a deliberate effort to train more family physicians.

This has been noted in the preliminary conclusions, Mr. Chairman, as you have heard today, from the Council of Graduate Medical Education.

The Federal investment in family practice to date has yielded significant societal benefits, including improvement in specialty and geographic distribution. Family physicians care for patients of all ages, including the geriatric population, and they are having significant responsibility in the diagnosis and caring of patients with AIDS.

Family practice residency graduates practice in rural and underserved areas and provide ambulatory-based preventive health care, a care which seems to be the aim of the current Administration and of Congress. Our aim is to keep people active and self-sufficient.

However, with this ambulatory-based training model, Mr. Chairman, family practice education faces unique and challenging financial constraints. The current Medicare reimbursement system, which discourages preventive care and reimburses family physicians less than other specialists, is a major contributor to the financial fragility of all family practice education.

Continued and enhanced Federal support, targeted to both departments of family medicine under Section 780, and to residency programs in family medicine under Section 786, is necessary to maintain the gains that we have already made and to further improve access to health care.

As you know, the current statutory language specifies that 7.5 percent of the funds appropriated for Section 786 be set aside for dentistry residency programs. The Academy strongly urges this Committee to reject any efforts to increase this funding for dentistry at the expense of family practice programs.

We are deeply appreciative of the support this Committee has given to family practice in the past and look forward to continuing to work with you on the reauthorization of important Federal funds.

Quoting the Administration regarding the current funding, they suggest that the new program should allow for attention to expanding elderly population, a program that will develop a capacity to care for people as outpatients rather than as costly inpatients, and a program which will train health professionals, that will provide care where it is needed, in rural and underserved populations.

Mr. Chairman, I suggest to you that this new program that the Administration speaks of is the current program Congress has been funding. It is funding to family practice residency programs, and it is funding to family practice departments of medicine.

Thank you, Mr. Chairman. I would be happy to answer any questions.

[The prepared statement of Dr. Morley, with attachments, follows:]

STATEMENT of the American Academy of Family Physicians

REAUTHORIZATION OF HEALTH PROFESSIONS TRAINING PROGRAMS
FOR FAMILY PRACTICE UNDER TITLE VII PUBLIC HEALTH SERVICE ACT

before the

Senate Committee on Labor and Human Resources

April 28, 1988

Presented by

Andrew P. Morley, Jr., M.D.
Chairman, Board of Directors

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Mr. Chairman, I am Andrew P. Morley, Jr., M.D., currently the Chairman of the Board of Directors of the American Academy of Family Physicians. The Academy is the medical specialty society which represents over 60,000 family physicians, residents and medical students. It is my pleasure to appear before this committee today to discuss with you the important role of the federal government in helping to ensure access to health care through training of family physicians and other primary care providers. I hope that my testimony will help you in your efforts here in Congress to enact legislation reauthorizing support for health professions education.

In the following statement, I will review with you the significant role that targeted federal funds have had on improving specialty and geographic distribution, explain the need for continuing support to sustain the progress that has been made to date, and emphasize the unique aspects of primary care graduate medical education that make it so beneficial to society yet subject to difficult financial challenges in the current system.

Family Practice:

First, I would like to discuss with you the specialty of family practice. Family physicians provide ambulatory-based, cost-effective, preventive-oriented care to a broad population of this country. According to 1985 data from the National Ambulatory Medical Care Survey (NAMCS), 30.5 percent of visits to office based physicians in the U.S. were to family physicians (Attachment A).

Because the elderly represent a sizable portion of this population served by family physicians, geriatric health care is an important part of the family physician's training and practice. Care provided by family physicians is aimed at keeping the elderly person active, mobile and self-sufficient. According to NAMCS 1985 data, visits to family physicians represented 29.1 percent of the visits to all physicians by the nation's 26.6 million residents age 65 and over (Attachment B). This fact is particularly important for the Medicare program, in view of initiatives to seek alternatives to costly inpatient care and to encourage less expensive, ambulatory based care.

In addition to the elderly, data indicate that family physicians care for a significant percentage of the pediatric age population. We estimate that 20 to 25 percent of pediatric care is provided by family physicians. While information on physician participation in the Medicaid program is limited, survey data published in a recent Office of Technology Assessment (OTA) report, "Healthy Children - Investing in the Future," indicate that 86.8 percent of family physicians participate in Medicaid and that on average 10.6 percent of their practices are Medicaid patients.

Because of their multidisciplinary training, family physicians are able to care for 85 percent of the problems that present in their offices and are particularly adaptable to the diverse needs presented in various geographic areas. Family physicians are continuing to locate in shortage and rural areas thus continuing to address the national problem of geographic maldistribution. Data from the 1986 survey of family practice residency graduates indicate that 90 percent enter family practice (as opposed to subspecialization, fellowships, etc.) and that over 47 percent locate their practices in rural and suburban communities of less than 25,000 (Attachment C).

We would further emphasize that because of the nature of their training, family physicians are the physician of choice for placement in remote National Health Service Corps sites. These physicians are equipped to care for people of all ages, to treat a myriad of health conditions, and often, in remote locations, to provide care without immediate access to other specialists for referral.

Because I know that the members of this committee have a particular interest in the care of people with AIDS, I want to emphasize that family physicians' responsibilities in prevention, patient education, infection control, and treatment of patients affected by HIV infection are growing rapidly. The Academy currently is developing core curriculum guidelines concerning AIDS for use in family practice residency programs. The family practice community is committed to preparing medical students, residents and practicing family physicians to care for AIDS patients. And we encourage a continuation of the federal commitment to train family physicians who are a national resource to help address the AIDS epidemic.

We firmly believe that the development and growth of family practice has helped correct both specialty and geographic maldistribution of physician services. Maintenance of the progress to date and further improvements in these national problems will require continued and intensified federal commitment.

The Federal Role

For two decades the federal government has provided funding to improve access to health care in this country. Initially, the federal support was broad based, with the objective of improving access through increases in the numbers of physicians trained. With success in achieving growth in the aggregate numbers of physicians, Congress turned its attention to the more focused problems of specialty and geographic maldistribution. A major policy decision was to use federal funds to encourage growth in the specialty of family practice. Through targeted support at the medical school level aimed at putting departments of family practice on equal footing with more established medical specialties, and through support of family practice residency programs, this growth has been significant.

Section 786 of the Public Health Service Act provides support to family practice residency programs with a set aside of 7.5% of funds appropriated for general dentistry programs. The funding provided for Section 786 in this fiscal year will support approximately 3,800 residency positions, will enhance faculty development programs, and through the predoctoral projects is expected to benefit over 13,000 medical students. The funding level for Section 786 currently is 35.405 million.

Section 780 supports family medicine departments within medical schools. Of the 138 medical schools, 109 now have departments of family medicine, and 11 have other administrative entities in family medicine. The $6.7 million appropriated for this section is funding 57 projects and will provide more than 11,000 medical students with exposure to family practice.

The number of family practice residency programs, which experienced tremendous growth from the inception of the specialty in 1969 until 1982, has now stabilized at approximately 382 programs with 2,456 first year residents. The growth in family practice residency programs began to level off in 1983, paralleling the leveling off of federal support of family practice training programs.

The leveling off in the number of residency programs and positions is accompanied by a projected high rate of retirement from practice by the more than one-third of family physicians/general practitioners age 55 and older. This impending decrease in supply of family physicians is therefore a realistic expectation. These two trends will reduce the number of family physicians in practice at a time when the demand for family physicians is increasing.

As a percentage of the total resident population in 1985, family practice represented 9.8 percent, and the combined primary care specialties of family practice, pediatrics and general internal medicine represented only 30.5 percent of total residency positions.[1],[2] This 9.8 percent is small relative to the significant demand for care provided by family physicians, and relative to the projected growth in the population, particularly among the elderly.

The federal investment in family practice training has, and will continue to pay off -- and the beneficiaries of increased access to health care resulting from decreases in specialty and geographic maldistribution, are the American people.

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[1] Medical Education in the U.S. 1985-1986. JAMA 1987; 256 (12):1588.

[2] Kallenberg G, Riegelman R, Hockey L. Waiting for the Doctor Glut, or is the Calvary Really Coming. Journal of General Internal Medicine. 1987;2:252.

Uniqueness of Family Practice Training

As a specialty with a unique training model, family practice has been faced with difficult financial constraints. Over two-thirds of these residency programs are located in community hospitals, rather than located in traditional tertiary medical centers. In addition to the community hospitals, family practice residency programs are exploring affiliation with community health centers, migrant health centers and free clinics. Location in non-traditional training sites, coupled with an ambulatory-based training model which emphasizes training in a family practice center to simulate practice in a physician's office, provide family practice residency programs with significant financial challenges.

Studies of these programs indicate a cost distribution of approximately one-third resident salaries/fringe benefits, one-third faculty and administrative costs, and one-third overhead costs of the family practice center. Revenue sources are largely comprised of government support, practice revenues and hospital support. Over two-thirds of family practice programs have direct state support, and one half of the programs have had federal training grant support. Due to the emphasis on ambulatory and preventive care, reimbursement from Medicare and other third party payors is less than for inpatient, procedurally oriented care. Patient care revenues have been unable to support the training programs, and it appears unlikely they ever will be able to do so under the current reimbursement structure. Experience indicates that revenues from patient care are able to fund only one-third of the cost of family practice residency training. As a result of these factors, family practice programs are unable to become "self-sufficient" from patient care revenues, unlike many inpatient based specialty training programs. Continued and enhanced targeted federal support is essential for family practice programs to continue to thrive.

The FY 1989 Administration Proposal

However, we are faced now with a budget proposal developed by the Administration that would decrease funding for health professions education programs in the aggregate from $212 million to a mere $40 million, to be structured in "block grants." In its explanation of the proposal, the Administration states, "The new program will allow increased attention to the expanding elderly population, will develop the capacity to care for people as outpatients, rather than on the more costly inpatient basis, and will train health care professionals committed to providing care to rural and other underserved populations." This description of a "new" program describes exactly what family practice programs already are doing: providing training in the care of geriatric patients as an integral part of the residency program, providing ambulatory based training to prepare the resident for ambulatory based practice, and preparing and encouraging residency graduates to practice in rural and other underserved populations. A new program is not necessary. What is necessary is a sufficient funding level to continue current efforts to train sufficient numbers of primary care physicians.

We therefore urge this committee to reject both the funding levels and the structure proposed by the Administration. Rather, we applaud you for having this hearing to examine health professions training efforts, and encourage you to develop legislation which will reauthorize family practice and other primary care training programs which have helped address the nation's health care needs.

Conclusions of the Council on Graduate Medical Education (COGME)

COGME has been examining both the supply of and demand for physicians, with its preliminary conclusions specific to primary care specialties of general internal medicine, general pediatrics and family practice. In its preliminary recommendations, COGME has concluded that "there is an undersupply of physicians in family practice." COGME then recommends that "incentives such as grant programs, revisions in Medicare and Medicaid reimbursement policies and student loan repayment programs must be provided to assure that sufficient numbers of primary care residency programs and positions are available to meet the needs of society."

Summary

The American Academy of Family Physicians believes that the goal of assuring access to quality health care by the American people can be met only if the supply of physicians is appropriate to meet the demand for services. Given the current demand for services of family physicians, the supply is inadequate and will remain so without deliberate efforts to train more family physicians. The federal investment in family practice to date has yielded significant societal benefits, including improvement in specialty and geographic maldistribution. However, with its ambulatory based training model, family practice training faces unique and challenging financial constraints. Continued and enhanced federal support targeted to both departments of family medicine (Section 780 of the Public Health Service Act) and to residency programs in family practice (Section 786 of the PHS Act) is necessary to maintain the gains already made and to further improve access to health care.

As you know, the current statutory language specifies that 7.5 percent of the funds appropriated for Section 786 be allocated to dentistry programs. The Academy strongly urges this committee to reject any efforts to increase the funding for dentistry at the expense of family practice programs.

We are deeply appreciative of the support that this committee has given to family practice in the past and look forward to continuing to work with you on the reauthorization of these important federal programs. Thank you for the opportunity to share our views with you. I would be pleased to answer any questions at this time.

– Attachment A

II-B-1 NUMBER AND PERCENT DISTRIBUTION OF OFFICE VISITS BY PHYSICIAN SPECIALTY, TYPE OF PRACTICE, AND PROFESSIONAL IDENTITY: UNITED STATES, 1985

Physician Specialty, Type of Practice and Professional Identity	Number of Visits in Thousands	Percent Distribution
TOTAL Visits	636.386	100.0
Family Practice	193.995	30.5
Internal Medicine	73.727	11.6
Pediatrics	72.693	11.4
Obstetrics and Gynecology	56.642	8.9
Ophthalmology	40.062	6.3
Orthopedic Surgery	31.482	4.9
General Surgery	29.858	4.7
Dermatology	24.124	3.8
Psychiatry	17.989	2.8
Otorhinolaryngology	16.097	2.5
Urological Surgery	11.699	1.8
Cardiovascular Disease	10.617	1.7
Neurology	4.992	0.8
All Other Specialties	52.408	8.2
Type of Practice		
Solo	323.653	50.9
Partnership	113.317	17.8
Other[1]	199.416	31.3
Professional Identity		
Doctor of Medicine	600.514	94.4
Doctor of Osteopathy	35.872	5.6

[1] Includes group practice and other.

Source: *U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, 1985 Summary: National Ambulatory Medical Care Survey, January 23, 1987, Number 128, p. 8.*

Attachment B

II-B-2 NUMBER AND PERCENT DISTRIBUTION OF OFFICE VISITS BY SEX AND AGE OF PATIENT AND BY FAMILY PHYSICIANS AND OTHER PHYSICIANS: UNITED STATES, 1985

	All Physicians		Family Practice Physicians		Other Physicians[1]	
Sex and Age of Patient	Number of Visits in Thousands	Percent Distribution	Number of Visits in Thousands	Percent Distribution	Number of Visits in Thousands	Percent Distribution
TOTAL	636,386	100.0	193,995	100.0	442,391	100.0
Female						
TOTAL Female	387,481	60.9	117,686	60.7	269,795	61.0
Under 15 years	58,175	9.1	14,699	7.6	43,475	9.8
15-24 years	48,883	7.7	16,679	8.6	32,204	7.3
25-44 years	118,557	18.6	35,797	18.5	82,760	18.7
45-64 years	82,331	12.9	26,915	13.9	55,416	12.5
65 years and over	79,535	12.5	23,595	12.2	55,940	12.6
Male						
TOTAL Male	248,906	39.1	76,310	39.3	172,593	39.0
Under 15 years	60,594	9.5	14,960	7.7	45,633	10.3
15-24 years	25,081	3.9	9,672	5.0	15,408	3.5
25-44 years	57,167	9.0	20,251	10.4	36,917	8.3
45-64 years	55,060	8.7	17,081	8.8	37,978	8.6
65 years and over	51,004	8.0	14,346	7.4	36,657	8.3

[1] Excludes physicians in anesthesiology, pathology or radiology.

Source: *U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, National Ambulatory Medical Care Survey, unpublished data.*

Senator MATSUNAGA. Thank you very much, Dr. Morley. You finished much sooner than any of the other witnesses, and I congratulate you for it. Do you have to catch a plane or something?

Dr. MORLEY. No, sir. [Laughter.]

No, sir. I just wanted more time for questions, Mr. Chairman.

Senator MATSUNAGA. In your testimony, Dr. Morley, you have noted that the supply of family practitioners is falling. The number of medical students choosing family medicine has not significantly increased, and the older family physicians are retiring. Are the programs supporting family medicine departments and residency programs all that the Federal Government could be doing, or should the Government be doing something else over and above what it is doing now?

Dr. MORLEY. I think what the Government is doing right now, Mr. Chairman, has been excellent, and we have gone a long way; we need to go further. If we weren't under budgetary constraints, I would be sitting before you today, asking for more money, but I cannot do that in all good faith.

What I can do, however, is say that we need the continued support of the Congress to make sure that we expand our current programs of family practice departments.

If you will notice, not every medical school in this country has family practice departments. We have a goal to do that, and if we can do that, the statistics show that those new departments will enhance or increase the number of students within those medical schools to go into family medicine. And that is why it is so important to keep the current level of funding, Senator.

Senator MATSUNAGA. One of the intended effects of stimulating the development of family medicine departments and residency was to increase the number of students choosing family medicine and primary care, but this has not occurred.

How would you explain that?

Dr. MORLEY. If I could, Mr. Chairman, I think it has occurred in many of the medical schools in this country. I will speak to two medical schools that I am very familiar with, the Medical College of Georgia and Emory University.

Over the past five years, without a family practice department, just with what the student interest groups have done there, we have seen a significant increase in the number of graduates at Emory University going into family medicine or electing that specialty. At the Medical College of Georgia, with a strong Department of Family Practice, we continue to see an increased number of medical students electing family medicine as their career.

Senator MATSUNAGA. Statistics across the country, however, show a decrease in total numbers, and I was wondering how we could achieve the success of the colleges and universities you have mentioned in the rest of the country.

Dr. MORLEY. A great deal of hard work and continued funding, Mr. Chairman—continued funding by Congress, we hope, and continued hard work by us. The American Academy is continuing to develop a tremendous number of programs getting into these other medical schools across the country and trying to do just that.

Senator MATSUNAGA. But it appears that the medical students are entering into specialties which bring in higher salaries.

Dr. MORLEY. I totally agree with that, Mr. Chairman, and that is one of the problems that we are having in family medicine: a) family physicians are reimbursed less than other specialists right now, for the things that are very important to the American people. Preventive medicine and what we call cognitive services, just caring for people, are not reimbursed at the levels where people can go in as other specialties and do things that take a fourth of the time and make four times the money. We have to address that issue. We have got to address the issue of medical debt for medical students. If you incur a debt in medical school of $35,000 to $40,000, and you are also electing into a specialty that even though the American public wants, isn't being reimbursed the way it should be, then that certainly is a disincentive, sir.

We are addressing those issues. I hope the family of medicine is, with the relative value studies coming out. And I know we are addressing that issue in family medicine.

Senator MATSUNAGA. If we have any more questions, and if Senators on this Committee who are absent have any questions, they may submit those questions to you in writing. If you would respond in writing to those questions for the record, we would appreciate it very much.

I wish to thank you again, Dr. Grace and Dr. Morley, for appearing before this Committee despite your busy day. Thank you very much.

Dr. GRACE. Thank you, Mr. Chairman.

Dr. MORLEY. Thank you, Senator.

[Additional material submitted for the record follows:]

DR. DAVID SUNDWALL

Questions from Senator Orrin G. Hatch (R-UT)

Q. Could you please comment on what you see as the Nation's major health manpower needs over the next three years?

A. The Nation's major health manpower needs include improving the supply and distribution of primary care providers, enhancing the availability of health personnel in rural or other underserved areas, strengthening training of health care providers in the care of the elderly, assuring adequate educational opportunities for minorities and disadvantaged students, meeting nursing needs, and training adequate numbers and types of personnel to deal with HIV/AIDS and other emerging health care problems. The Federal Government has an interest also in enhancing the quality of health care through the encouragement of appropriate health personnel quality assurance efforts.

Q. Which of the existing programs in Title VII best meet the needs you have identified?

A. Title VII programs such as those for training primary care physicians, providing educational assistance to students from disadvantaged backgrounds, supporting the development of training centers in areas remote from the main campuses of medical schools (Area Health Education Centers), and providing for loans to cover educational costs of financially needy health professions students have assisted in meeting the Nation's health manpower needs. However, the existing multiplicity of categorical authorities--each with its own eligibility provisions, program requirements, and funding authorizations--has constrained our ability to adapt Federal assistance in any given year to priority needs.

Q. What changes should be made to Title VII to improve the ability to meet these needs?

A. The Administration believes that the Federal Government can best utilize funds to accomplish national priority health personnel objectives under a flexible authority that allows adaptation to changing needs. We have proposed that the existing categorical health professions education authorities be replaced by a unified comprehensive authority for competitive grants to, or cooperative agreements with, States and other public or private entities for projects to meet high priority health personnel needs.

Priority would be given to projects that encourage cooperation among related health and educational entities; that maximize non-Federal involvement in the identification of problems and the planning of programs to address those problems; that, as appropriate, promote the recruitment and retention of ~~minorities~~ in the health professions; and that would be funded, from the outset, at a level of more than 50 percent from non-Federal sources.

the disadvantaged

We further propose certain changes in the laws governing operation of the Health Professions Student Loan program and the Health Education Assistance, or HEAL, program as authorized in Title VII. These changes, which we submitted to the Congress in a draft bill (the "Health Professions Loan Amendments of 1987") last November, are designed to strengthen the management of the programs and to make them more cost effective. I hope that the Committee will give full consideration to the merits of each of the proposed amendments.

Q. Which programs in Title VII should be eliminated because they do not address these needs?

A. The particular measures that should be taken by the Department in any given year to deal with priority health personnel issues should be determined in consultation with the States and other non-Federal institutions and agencies that are most familiar with local and regional personnel needs and available training resources. Our proposed Cooperative Health Professions Initiatives program would place heavy reliance on the help of non-Federal groups in the planning of necessary types of aid. We would expect long-range financial support to come from State and local governments and the private sector.

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The Honorable Edward M. Kennedy
Chairman, Committee on Labor and Human Resources
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

I am writing in reference to your letter of May 13, 1988, which requested responses to questions from Senator Hatch regarding the views of the Council on Graduate Medical Education (COGME). I appreciate this opportunity to respond on behalf of the Council.

As you may know, the first report of COGME will be submitted to Congress and the Department of Health and Human Services next month. Since Council members will shortly be reviewing the final draft of the report, my remarks still need to be formally considered as a "tentative Council response." At the same time, I should add my personal view that it is highly unlikely that the upcoming final Council review will result in any significant, substantive change to the conclusions and recommendations developed to date.

I have enclosed a detailed response to the questions included in your letter. Please do not hesitate to contact me if I can be of further assistance.

Sincerely yours,

Neal A Vanselow

Neal A. Vanselow
Chairperson
Council on Graduate Medical Education

Enclosure

Response to Questions Raised in May 13, 1988 Letter from Senator Edward M. Kennedy

Although Title VII is concerned with health professions generally, the scope of COGME is considerably narrower as defined in statute. For its first report, the Council confined itself to addressing the adequacy of physician supply in the aggregate and the supply of primary care physicians. Other areas of direct relevance to Title VII addressed by the Council included: geriatrics and preventive medicine; the geographic distribution of physicians; representation of minorities in medicine; and manpower data and research needs.

Based upon the data and testimony received, the Council has concluded that there is now or soon will be an aggregate oversupply of physicians in the United States. At the same time, however, members have noted that there are significant uncertainties which could change this assessment. With a rationale described more fully in our report, the Council does not believe that the Federal government should attempt at this time to influence physician manpower supply in the aggregate. Consequently, the Council would not endorse any proposed changes to Title VII for the purpose of increasing or decreasing the aggregate supply of physicians.

With regard to primary care specialties, the Council has concluded that there is an undersupply of physicians in family practice, and an impending undersupply of physicians in general internal medicine. It has concluded that there appears to be an adequate supply of pediatricians at present but that there is a projected oversupply of pediatricians based on current health policy regarding insurance coverage for children. The Council has noted that this assessment could change significantly if policy were changed to extend health care coverage more broadly to the substantial numbers of uncovered children. With these conclusions in mind, the Council encourages increased training in primary care, particularly in family medicine and general internal medicine. It recommends that existing Title VII primary care grants (Sections 780, 784, and 786) and other support for primary care programs be expanded.

Based on testimony received at its Public Hearing, as well as its own review of current health manpower needs and graduate medical education financing, the Council believes that additional emphasis is warranted in the general areas of geriatrics and preventive medicine. Again with rationale oulined in the report, the Council recommends that it is necessary to continue and expand Federal, State, and private sector support for these areas. Although COGME did not focus specifically on Title VII in this regard, it would appear that its conclusions and recommendations could relate to geriatric authorities under Section 788 and to the authority pertinent to preventive medicine residencies (Section 793).

In its first report, the Council will express its concern regarding the continuing geographic maldistribution of physicians and, in view of the complexities of the involved problems, will indicate the need for solutions more broadly based than those focusing exclusively on medical education. The Council will recommend that existing activities which increase the likelihood that physicians will locate and remain in shortage areas should be continued and strengthened. This is of particular relevance to the Area Health Education Center program (Section 781) and other provisions in the Public Health Service Act more generally (eg. loan repayment programs; National Health Service Corps; Indian Health Service).

The continuing underrepresentation of minority physicians in the U.S. will be given considerable attention in the COGME report, with a series of recommendations to remedy this pressing health manpower need. The Council will recommend that high priority for public and private funding should be given to those programs which have achieved success in and/or demonstrated new and innovative approaches to the recruitment and retention of underrepresented minorities. The recommendations also call for a strengthened, balanced student financial aid program and financial support to increase the number of underrepresented minorities in faculty positions at U.S. medical schools. Title VII authorities of relevance here include Sections 758, 788A, and 787.

The work of the Council to date has been hampered both by the existing state of the art regarding health manpower data and research, and the available resources provided to support its operations. Consistent with its statutory charge, the Council has identified a number of important shortcomings in manpower data. To facilitate work in this area, the Council is recommending annual authorization and appropriation levels of $1.5 million to support its future efforts. Sections 708 and 799 of Title VII are both of relevance in this regard.

Following is a list of the Council's conclusions and recommendations which are under final review. Recommendations which relate to Title VII have been checked.

5/16

DRAFT FINAL CONCLUSIONS AND RECOMMENDATIONS
Council on Graduate Medical Education

A. PHYSICIAN SUPPLY IN THE AGGREGATE

CONCLUSION A-1. BASED UPON THE DATA AND TESTIMONY IT HAS RECEIVED, THE COUNCIL HAS CONCLUDED THAT THERE IS NOW OR SOON WILL BE AN AGGREGATE OVERSUPPLY OF PHYSICIANS IN THE UNITED STATES. THE COUNCIL NOTES, HOWEVER, THAT THERE ARE SIGNIFICANT UNCERTAINTIES WHICH COULD CHANGE THIS ASSESSMENT. BECAUSE OF THE MANY FACTORS AFFECTING BOTH THE SUPPLY OF PHYSICIANS AND THE DEMAND FOR PHYSICIAN SERVICES, THE COUNCIL IS UNABLE EITHER TO MEASURE THE EXTENT OF THE OVERSUPPLY OR TO PREDICT HOW FAR INTO THE FUTURE IT WILL PERSIST.

CONCLUSION A-2. THERE IS CONFLICTING EVIDENCE AS TO WHETHER AN OVERSUPPLY OF PHYSICIANS WOULD NECESSARILY LEAD TO SOCIALLY UNDESIRABLE CONSEQUENCES.

> Recommendation 1. At the present time, the Federal government should not attempt to influence physician manpower supply in the aggregate.
>
> Recommendation 2. The number of first year positions in graduate medical education should not be used to reduce the supply of licensed physicians in the aggregate; rather, if steps are taken to reduce physician supply, the reduction should take place in entering medical school class size.
>
> Recommendation 3. The public and private sectors should focus their efforts on influencing clearly identified problems such as the geographic maldistribution of physicians, the continued underrepresentation of minorities in medicine, specialty shortages, and concerns regarding quality of care.

B. GEOGRAPHIC DISTRIBUTION OF PHYSICIANS

CONCLUSION B-1. THERE IS A GEOGRAPHIC MALDISTRIBUTION OF PHYSICIANS, WITH TOO FEW PHYSICIANS IN MANY RURAL AND INNER CITY AREAS.

CONCLUSION B-2. WHILE THERE CONTINUES TO BE AN INADEQUATE NUMBER OF PHYSICIANS IN MANY RURAL AND INNER CITY AREAS, THIS PROBLEM IS NOT AS SEVERE AS IT HAS BEEN IN THE RECENT PAST AND MAY WELL BE AMELIORATED, AT LEAST IN PART, AS THE OVERALL SUPPLY OF PHYSICIANS INCREASES.

CONCLUSION B-3. NEVERTHELESS, MALDISTRIBUTION REMAINS A SERIOUS AND COMPLEX PROBLEM, REQUIRING SOLUTIONS MORE BROADLY BASED THAN THOSE FOCUSING EXCLUSIVELY ON MEDICAL EDUCATION.

> Recommendation 4. Existing activities that increase the likelihood that physicians will locate and remain in shortage areas should be continued and strengthened, such as:
>
> a. recruitment and selection of allopathic and osteopathic medical students who are likely to locate in shortage areas;

b. medical school programs including preceptorships in shortage areas;

c. student financial support, such as loan repayment in exchange for service;

d. practice incentives (e.g., differential reimbursement, practice and community support); and

e. existing programs, Federally and State supported, such as the National Health Service Corps, to meet the needs of the underserved communities.

Recommendation 5. More research and evaluation should be conducted on factors relating to the geographic distribution of physicians and their services to assure that a broad range of existing and new strategies are directed to this complex problem.

C. MINORITY REPRESENTATION IN MEDICINE

CONCLUSION C-1. THERE IS STILL UNDERREPRESENTATION OF MINORITY PHYSICIANS IN THE UNITED STATES

CONCLUSION C-2. IT IS HIGHLY DESIRABLE TO INCREASE MINORITY REPRESENTATION IN THE MEDICAL PROFESSION FOR TWO REASONS:

TO ENSURE THAT MINORITIES HAVE EQUAL ACCESS TO A CAREER IN MEDICINE AND EQUITY IN HEALTH CARE SERVICES

MINORITY PHYSICIANS ARE MORE LIKELY THAN OTHERS TO PRACTICE THE PRIMARY CARE SPECIALTIES, AND THEY PROVIDE A GREATER PROPORTION OF HEALTH CARE FOR MEDICALLY UNDERSERVED POPULATIONS THAN OTHER U.S. PHYSICIANS

Recommendation 6. Creative and expanded efforts need to be undertaken by government, private industry, and the educational community to increase the number of underrepresented minority applicants qualified to enter and complete a medical education. This requires vigorous and aggressive efforts at both the high school and college level.

Recommendation 7. Successful minority recruitment programs should be examined to determine the reasons for their success for replication and implementation in other medical schools. Based on the previous and proven efforts of successful programs, medical schools should strengthen their recruitment programs by identifying undergraduate schools with sizable enrollments of qualified underrepresented minority students, and establish programs funded by public and private sources to support activities that will increase such students' interest in a career in medicine.

Recommendation 8. Medical schools should have programs to increase recruitment and to reduce attrition among minority students. Those schools which presently do not have successful programs should direct their attention to and make use of information from those programs which have successfully reached these goals. High priority for public and private funding should be given to those programs which have achieved success and to programs demonstrating new and innovative approaches.

Recommendation 9. Existing financial assistance programs should be strengthened by adopting a balanced strategy of scholarship, loan interest subsidy, and loan repayment programs to limit medical school debt, and to encourage schools to seek ways of reducing educational costs to students, particularly low-income and underrepresented minority students.

Recommendation 10. In order to expand the number of underrepresented minorities in faculty positions at U.S. medical schools, Federal, State and local governments should develop programs of financial support to accomplish this objective.

Private foundations should be urged to support programs to enhance minority representation in academic medicine. Those foundations currently so involved should be applauded and encouraged to increase their efforts.

Recommendation 11. In order to provide minority students with the opportunity for training in the full range of medical specialties, graduate medical education programs should be encouraged to develop and implement affirmative action policies to achieve that objective. In addition, such graduate medical education programs should be encouraged to provide appropriate role models for these medical students.

D. PRIMARY CARE AND OTHER PHYSICIAN SPECIALTIES

CONCLUSION D-1. THERE IS EVIDENCE OF AN UNDERSUPPLY OF CERTAIN PRIMARY CARE PHYSICIANS TOGETHER WITH AN OVERSUPPLY OF SOME NON-PRIMARY CARE SPECIALTIES.

CONCLUSION D-2. THERE IS AN UNDERSUPPLY OF PHYSICIANS IN FAMILY PRACTICE.

CONCLUSION D-3. THERE APPEARS TO BE AN IMPENDING UNDERSUPPLY OF PHYSICIANS IN GENERAL INTERNAL MEDICINE.

CONCLUSION D-4. THERE APPEARS TO BE AN ADEQUATE SUPPLY OF PHYSICIANS IN PEDIATRICS AT PRESENT. HOWEVER, THERE IS A PROJECTED OVERSUPPLY OF PEDIATRICIANS BASED UPON CURRENT HEALTH CARE POLICY REGARDING INSURANCE COVERAGE FOR CHILDREN. IF POLICY WERE CHANGED TO EXTEND HEALTH CARE COVERAGE MORE BORADLY TO THE SUBSTANTIAL NUMBERS OF UNCOVERED CHILDREN, THE FUTURE SUPPLY COULD RAPIDLY CHANGE TO BECOME ONLY ADEQUATE OR POSSIBLY INADEQUATE.

CONCLUSION D-5. ADDITIONAL EMPHASIS IS WARRANTED IN THE GENERAL AREAS OF GERIATRICS AND PREVENTIVE MEDICINE.

Recommendation 12. Allopathic and osteopathic medical school graduates should be strongly encouraged to enter training in primary care, particularly in family practice and general internal medicine. The general areas of geriatrics and preventive medicine should also be emphasized.

E. FINANCING GRADUATE MEDICAL EDUCATION

CONCLUSION E-1. SUPPORT FOR THE FINANCING OF GRADUATE MEDICAL EDUCATION IS ERODING AS PAYMENTS FOR PATIENT CARE ARE CONSTRICTED. SUBSTITUTE SOURCES ARE NOT DEVELOPING TO TAKE THEIR PLACE.

Recommendation 13. Funds to finance graduate medical education should continue to come from present sources: The Council recommends against making any major and/or precipitous changes in the way in which GME is financed. If changes are made in the way that GME is financed, such changes should take place gradually.

Recommendation 14. Except as modified by later recommendations, Medicare payments for direct costs of GME should continue to utilize existing sources, conduits, and recipients.

Recommendation 15. Until further data and analysis are available on the potential effect of reduced Medicare GME payments on teaching hospitals and training programs, the Council recommends that: (1) aggregate level of payments for graduate medical education be maintained at current levels; and (2) payments for direct GME costs continue to include all expense categories currently allowed.

During 1988-1989, the Council will assign high priority to a comprehensive review and analysis of Medicare GME payments and may make additional recommendations in an interim report.

Recommendation 16. The Council places the highest priority on reimbursement of residency training stipends and fringe benefit costs and on training in those primary care specialties which are in short supply, preventive medicine, geriatrics, and quality programs in underserved communities and for training of minorities. If reductions of direct costs should be made, these aspects of GME should be sheltered from the impact.

CONCLUSION E-2. GRADUATE MEDICAL EDUCATION IN AMBULATORY SETTINGS IS INCREASINGLY NECESSARY IN MANY SPECIALTIES FOR OPTIMAL TRAINING AND PREPARATION FOR PRACTICE.

Recommendation 17. The Council believes that a concerted focus on training in ambulatory settings is warranted.

CONCLUSION E-3. THERE ARE DIFFICULTIES IN FINANCING GME IN AMBULATORY SETTINGS, RELATED TO LOWER LEVELS OF PAYMENT BY THIRD PARTIES AND TO INCREASED LOGISTICAL PROBLEMS IN TEACHING. THE CURRENT FINANCING OF GME RESULTS IN DISINCENTIVES FOR AMBULATORY TRAINING.

> Recommendation 18. In order to facilitate the expansion of ambulatory/outpatient GME, and to encourage innovative program development and growth, all approved GME programs, including those based in ambulatory/outpatient settings, should be eligible for Medicare GME reimbursement. A methodology for reimbursement of direct and indirect costs for ambulatory training should be developed.
>
> Recommendation 19. Medicare and private organizations should carry out demonstrations of alternative methods of payment for graduate medical education in ambulatory and other non-traditional settings. It may be necessary to consider differential payment incentives to encourage and facilitate medical education in ambulatory and long-term care sites.

CONCLUSION E-4. THE FINANCING OF GRADUATE MEDICAL EDUCATION IS PARTICULARLY PROBLEMATIC FOR THE AREAS OF PRIMARY CARE, GERIATRICS, AND PREVENTIVE MEDICINE.

CONCLUSION E-5. THE PRESENT SYSTEM OF FINANCING DECREASES THE ATTRACTIVENESS OF CERTAIN DISCIPLINES TO STUDENTS, AND TENDS TO PRODUCE A CONCENTRATION OF PHYSICIANS IN WHAT MAY BE OVERSUPPLIED SPECIALTIES. THESE INCENTIVES ARE THE RESULT OF (1) DIFFERENTIALS BY SPECIALTY IN REIMBURSEMENTS TO PHYSICIANS FOR SERVICES APART FROM MEDICAL EDUCATION PAYMENTS, AND (2)DIFFERENTIALS BY SPECIALTY IN BENEFITS TO HOSPITALS FOR THE USE OF INPATIENT HOSPITALIZATION AND OTHER HOSPITAL SERVICES.

> Recommendation 19. Primary care, preventive medicine, and geriatric training programs should be encouraged.
>
> a. It is necessary to continue and expand Federal, State and private sector support for these programs.
>
> b. Existing Title VII primary care grants and other support for primary care programs should be expanded.
>
> Recommendation 20. The Council supports the recommendation of the Physician Payment Review Commission that primary care services be granted greater Medicare fee increases than other physician services, as a change in direction of relative payments to physicians that the Commission advocates for long-range reform.

F. MEDICARE FINANCING OF DIRECT AND INDIRECT COSTS OF GRADUATE MEDICAL EDUCATION

CONCLUSION F-1. THERE REMAIN UNEXPLAINED, SUBSTANTIAL VARIATIONS AMONG HOSPITALS IN PER-RESIDENT DIRECT COSTS.

> Recommendation 21. The study of the variation in per-resident direct costs should be carried out expeditiously. It should study per-resident costs well above the mean to define appropriate limits. Programs with lower per-resident costs should be studied to understand the reasons for the lower costs.

CONCLUSION F-2. CURRENT PAYMENTS ASSOCIATED WITH THE GME INDIRECT COST ADJUSTMENTS ARE USED TO COMPENSATE FOR HIGHER COSTS PER CASE ASSOCIATED WITH TEACHING HOSPITALS GENERALLY ATTRIBUTED TO GREATER SEVERITY OF ILLNESS WITHIN DRGs, GREATER USE OF DIAGNOSTIC TESTS, ETC. SOME OF THESE COSTS MAY NOT BE DIRECTLY PERTINENT TO MEDICAL EDUCATION.

> Recommendation 22. The reasons for the higher costs of teaching hospitals should be analyzed further with the goal of paying for medical education costs through the indirect teaching adjustment where justified and paying for other costs through alternative methods where that is more appropriate. The Council believes that any changes should take into account the overall effect on teaching hospitals.

G. FOREIGN MEDICAL GRADUATES AND RELATED CONSIDERATIONS

CONCLUSION G-1. THE PRINCIPLE OF INDIVIDUAL COMPETENCY AS THE DOMINANT CRITERION FOR SELECTION INTO GRADUATE MEDICAL EDUCATION SHOULD BE MAINTAINED. DIFFERENTIATION OF FOREIGN MEDICAL GRADUATES ON THE BASIS OF CITIZENSHIP OR IMMIGRATION STATUS IS CONTRARY TO THIS PRINCIPLE, AS WELL AS TO U.S. TRADITION, LAW AND ETHICAL CODE.

CONCLUSION G-2. IT IS HIGHLY DESIRABLE THAT ALL GRADUATES OF U.S. ALLOPATHIC AND OSTEOPATHIC MEDICAL SCHOOLS BE ABLE TO OBTAIN A PGY-1 POSITION IN A GRADUATE MEDICAL EDUCATION PROGRAM. HOWEVER, U.S. MEDICAL SCHOOLS' GRADUATES SHOULD NOT BE GRANTED AUTOMATIC PRIORITY OVER THE QUALIFIED GRADUATES OF NON-DOMESTIC MEDICAL SCHOOLS AS A MEANS OF ACHIEVING THIS GOAL.

CONCLUSION G-3. U.S. MEDICAL SCHOOLS ARE OBLIGATED TO PROVIDE THE BEST POSSIBLE EDUCATION WHICH WILL ALLOW ALL GRADUATES TO COMPETE EFFECTIVELY FOR GRADUATE MEDICAL EDUCATION POSITIONS. THEY SHOULD CAREFULLY EVALUATE ALL STUDENTS AND GRADUATE ONLY THOSE CONSIDERED UNEQUIVOCALLY QUALIFIED FOR GRADUATE MEDICAL EDUCATION.

> Recommendation 23. Selection into GME programs should be based on the relative qualifications of the individual applicants not on group or institutional associations.

Recommendation 24. For the purpose of limiting access to graduate medical education, the Federal government should not establish policies which would discriminate against medical school graduates on the basis of citizenship, immigration status, or medical school location.

CONCLUSION G-4. THE CURRENT SYSTEM FOR TESTING FMGs ON KNOWLEDGE IN THE BASIC MEDICAL AND CLINICAL SCIENCES IS GENERALLY ADEQUATE. WITH THE EXPECTED ADDITION OF A TEST FOR THE ASSESSMENT OF CLINICAL SKILLS AND A TEST OF SPOKEN ENGLISH, CURRENT CONCERNS REGARDING ASSESSMENTS FOR ENTRY INTO GME WILL HAVE BEEN ADDRESSED.

CONCLUSION G-5. IT WOULD BE BOTH PRESUMPTUOUS AND UNWISE FOR THE GOVERNMENT AND/OR THE PRIVATE SECTOR TO ATTEMPT TO ESTABLISH PROCEDURES FOR ACCREDITING MEDICAL SCHOOLS OUTSIDE ITS OWN TERRITORY.

Recommendation 25. Access to a single medical knowledge examination route for all candidates for GME should be implemented as soon as possible.

Recommendation 26. If a clinical skills assessment examination is introduced for the testing of graduates of U.S. medical schools for entry into GME, and a similar test exists for FMGs, one examination should be used in evaluating all candidates.

Recommendation 27. The private sector should be sensitive to bias in testing which may be caused by use of new testing technologies and methodologies.

Recommendation 28. Neither the government nor the private sector should establish a system for accreditation of foreign medical schools.

Recommendation 29. The private sector should endorse and assist the efforts of foreign countries to establish national or regional standards and procedures which will improve medical education in their medical schools.

CONCLUSION G-6. UNLESS ALTERNATIVE SYSTEMS FOR PROVIDING CARE ARE ESTABLISHED FIRST, EXCLUSION OF FOREIGN MEDICAL GRADUATES FROM GME PROGRAMS WILL REDUCE THE ABILITY OF A SMALL NUMBER OF HOSPITALS TO PROVIDE CERTAIN ESSENTIAL HOSPITAL-BASED MEDICAL SERVICES. THESE HOSPITALS SERVE A DISPROPORTIONATE SHARE OF THE POOR. AMBULATORY SERVICES WILL BE MOST IMMEDIATELY AND SEVERELY IMPACTED.

CONCLUSION G-7. NONPHYSICIAN HEALTH CARE PROVIDERS CAN PERFORM SOME OF THE TASKS NOW PROVIDED BY FMG RESIDENTS. HOWEVER, THE DEGREE TO WHICH NONPHYSICIANS CAN PERFORM TASKS USUALLY PROVIDED BY RESIDENTS VARIES MARKEDLY DEPENDING ON THE NATURE OF THE SPECIALTY AND THE LEVEL OF CARE PROVIDED.

Recommendation 30. If the Federal Government and/or the private sector were to develop policies which would reduce the number of foreign medical graduates in GME, alternative systems for delivering hospital-based medical care should be established in advance for those FMG-dependent hospitals which serve a disproportionate share of the poor.

Recommendation 31. If policies are adopted which would reduce the number of FMGs in GME, consideration should be given to the following:

a. A transition period should be allowed to enable hospitals to make necessary adjustments in GME programs. Temporary waivers should be provided for programs which offer high quality education and provide primary care in an underserved area or are serving a large indigent population since these programs may require more time to increase the complement of alternative full-time health care providers.

b. Federal and State Governments and the private sector should provide financial incentives to assist hospitals in replacing FMG residents with full-time physicians, residents who are graduates of U.S. medical schools, or other appropriate health care providers (e.g., educational loan repayment; bonus for tenure; partial payment of malpractice insurance).

H. FOREIGN MEDICAL GRADUATES AND INTERNATIONAL RELATIONS

CONCLUSION H-1. IT IS LIKELY THAT GME PROGRAMS WHICH HAVE TRADITIONALLY PROVIDED TRAINING FOR EXCHANGE VISITOR PHYSICIANS WHO RETURN TO THEIR HOME COUNTRIES WILL HAVE TO REDUCE THEIR EFFORTS IF FOREIGN PHYSICIANS ARE EXCLUDED FROM STIPEND/SALARY REIMBURSEMENTS.

CONCLUSION H-2. SOME COUNTRIES SEEKING U.S. ASSISTANCE FOR DEVELOPMENT OF THEIR PHYSICIAN MANPOWER ARE FINANCIALLY ABLE TO SUPPORT THESE EFFORTS; OTHERS, WITH LESS RESOURCES, ARE NOT. PARTICIPATION IN THE EXCHANGE VISITOR PROGRAM OF THE UNITED STATES BY PHYSICIANS FROM THIS LATTER GROUP OF COUNTRIES HAS BEEN STEADILY DECREASING IN THE LAST DECADE.

CONCLUSION H-3. THERE IS A NEED TO EXPAND AND MODIFY THE EDUCATIONAL OPPORTUNITIES FOR EXCHANGE VISITOR PHYSICIANS TO BETTER MEET THE HEALTH CARE DELIVERY NEEDS OF THE HOME COUNTRY, AND TO ENHANCE RELATIONS WITH DEVELOPING COUNTRIES.

Recommendation 32. Exchange visitors in traditional GME should continue to be supported like all other participants in GME. Patient care funds should continue to support the proportion of activities that actually provide patient care. Home country, the trainee's own funds, foreign aid funds, or other sources of funds should be used to support nontraditional educational experiences of the exchange visitor.

Recommendation 33. To encourage reestablishment in the home country, the 2-year return home requirement should be modified to increase the number of years to 5 years. This would contribute to a longer period of time for reacculturation before reentry possibilities into the United States are available.

Recommendation 34. The public and private sectors should support the efforts underway to implement the International Medical Scholars Program. This support should be both monetary and programmatic.

Recommendation 35. Since training in traditional GME may not be appropriate for many exchange visitors, additional alternative programs should be developed. All appropriate bodies, both in the public and private sectors, should assist with the development of programs which would be broader than or different from classic clinical training. Although more expensive (but probably more effective), training assistance should be conducted in settings which involve both the home country and the U.S. Funding resources for this effort should be sought from the U.S./home country governments, international corporations, and private foundations.

I. STRUCTURE AND CONTENT OF MEDICAL EDUCATION

CONCLUSION I-1. THOSE WHO BEAR THE COST OF GME, INCLUDING PAYERS AND INSTITUTIONS, HAVE HAD LITTLE TO SAY ABOUT THE LENGTH OR CONTENT OF TRAINING PROGRAMS. LENGTH OR CONTENT REQUIREMENTS CAN BE ADDED WITHOUT ADEQUATE INPUT OF INDIVIDUAL INSTITUTIONS OR PAYERS, EVEN THOUGH THIS RESULTS IN INCREASED COSTS FOR THE INSTITUTION SPONSORING THE TRAINING PROGRAM.

Recommendation 36. Certifying boards and and accrediting bodies should provide maximum early opportunity for input from institutions and payers in considering changes the length or content of graduate medical education training programs. Certifying boards and accrediting bodies should be required to justify changes that would increase the length of training or would add a research component to a clinical training program. The Council urges the parents of the ACGME to convene for the purpose of determining methods by which this recommendation can be implemented, and the ABMS to bring this to the attention of its individual boards.

Recommendation 37. In view of educational and other concerns that relate directly to their professional future, medical students and residents should also be given the same opportunity for early input.

CONCLUSION I-2. IN SOME GME PROGRAMS THE QUALITY OF THE EDUCATION HAS BEEN ADVERSELY AFFECTED BY EXCESSIVE SERVICE REQUIREMENTS.

Recommendation 38. Residency approval bodies should pay particular attention to excessive service loads.

Recommendation 39. The Federal government and the private philanthropic sector should provide resources to study and develop alternative teaching/service models in service intensive settings. Successful models should be shared with the medical community and institutionalization of these models encouraged.

CONCLUSION I-3. THE COUNCIL SHARES THE CURRENT CONCERNS ABOUT EXCESSIVE RESIDENT DUTY HOURS AND INADEQUATE SUPERVISION AND THEIR IMPACT ON THE QUALITY OF PATIENT CARE AND RESIDENT EDUCATION.

Recommendation 40: The Council is supportive of efforts to resolve the problems of resident physician fatigue and inadequate supervision, but it cautions against global solutions which may be insensitive to local variation in patient loads and service requirements.

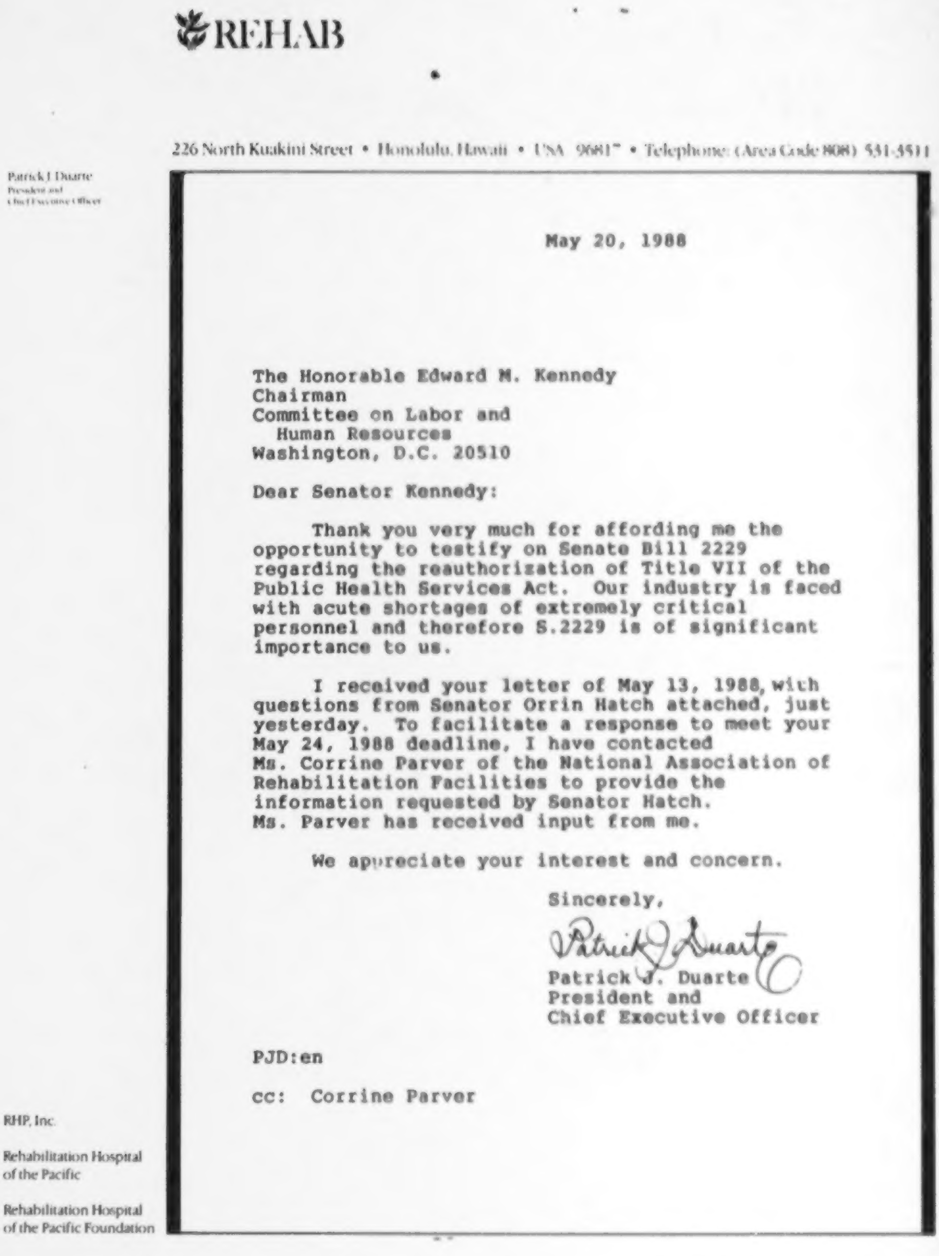
J. DATA AND RESEARCH ISSUES

CONCLUSION J-1. PHYSICIAN MANPOWER ANALYSIS, DEVELOPMENT OF HEALTH POLICY, AND PLANNING CONTINUE TO BE HAMPERED BY CONSIDERABLE LIMITATIONS IN DATA AND RESEARCH.

Recommendation 41. Adequate public and private sector funding should be provided to support the demonstration models, studies, and data-related activities recommended in this report, and as needed to carry out the long-term agenda.

Recommendation 42. The Council recommends that annual authorization and appropriation levels of $1.5 million should be provided to COGME to assure that adequate resources are available to support its analytic agenda, and meet its necessary staff and meeting expenses.

Recommendation 43. Given ongoing resource concerns, priority should be given to collaborative public and private sector activities regarding data and research activities wherever possible and appropriate.



REHAB

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Patrick J. Duarte
President and
Chief Executive Officer

May 20, 1988

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and
Human Resources
Washington, D.C. 20510

Dear Senator Kennedy:

Thank you very much for affording me the opportunity to testify on Senate Bill 2229 regarding the reauthorization of Title VII of the Public Health Services Act. Our industry is faced with acute shortages of extremely critical personnel and therefore S.2229 is of significant importance to us.

I received your letter of May 13, 1988, with questions from Senator Orrin Hatch attached, just yesterday. To facilitate a response to meet your May 24, 1988 deadline, I have contacted Ms. Corrine Parver of the National Association of Rehabilitation Facilities to provide the information requested by Senator Hatch. Ms. Parver has received input from me.

We appreciate your interest and concern.

Sincerely,

Patrick J. Duarte

Patrick J. Duarte
President and
Chief Executive Officer

PJD:en

cc: Corrine Parver

RHP, Inc.

Rehabilitation Hospital
of the Pacific

Rehabilitation Hospital
of the Pacific Foundation

NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

[illegible]
[illegible]

John A. Doyle
Executive Director

May 24, 1988

The Honorable Edward M. Kennedy
Chairman
Senate Labor & Human Resources Committee
U.S. Senate
Hart Office Building, Room 527
Washington, D.C. 20510

Re: Health Professions
Reauthorization Act of 1988

Dear Senator Kennedy:

On behalf of Patrick J. Duarte, I am pleased to respond to your letter dated May 13, 1988, in which you requested answers to several questions posed by Senator Orrin Hatch on the reauthorization of Title VII.

1. **Could you please comment on what you see as the nation's major health manpower needs over the next three year?**

The most significant health manpower needs rehabilitation facilities face now and in the foreseeable future is the shortage of rehabilitation professionals, such as physical therapists, occupational therapists, and speech-language pathologists and audiologists. As well, there is a marked shortage of rehabilitation nurses. There are few places in our country that do not have such shortages. Historically, these professions have been staffed by women. As more alternative career opportunities open up to women, the number of rehabilitation professionals leaving the workforce is increasing and the number of new graduates is decreasing.

From a rehabilitation industry standpoint, we foresee a growing need for rehabilitation therapy and an insufficient number of physical therapists, occupational therapists, speech-language pathologists and audiologists to treat the increasing numbers of patients. The shortage of physical therapists already has manifested itself in most areas of the country. Occupational therapy shortages are being reported more frequently. Recruiting speech-language pathologists and audiologists is becoming increasingly difficult. These manpower shortages will not only cause health care to be more expensive, but also could severely restrict access to quality care. There is no evidence that the shortage

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crisis will reverse itself over the next three years. In fact, we can probably expect it to get worse.

2. Which of the existing programs in Title VII best meet the needs you have identified?

Title VII of the Public Health Service Act historically has provided funds for the education of allied health professionals, including the rehabilitation professionals described in response to Question 1. However, there has been virtually no federal assistance for allied health professionals funding since 1980, either for institutional support, in the form of grants for education programs for rehabilitation professionals, or student assistance, in the form of loans, loan guarantees and scholarships. Thus, the problem remains that the current Title VII programs, which theoretically could offer some assistance in relieving the personnel shortages, have been so grossly underfunded that they have had, for all practical purposes, no merit.

3. What changes should be made to Title VII to improve the ability to meet these needs?

All programs in Title VII that target federal support for the training of allied health professionals should be reauthorized and funded at least at the levels proposed by S.2229, the Health Professions Reauthorization Act of 1988. We welcome the much needed addition in S.2229 of funding for allied health students in the areas of program development, assistance to doctoral students and direct assistance to entry level students in rehabilitation professions. We also welcome the addition of allied health to the Health Education Assistance Loan (HEAL) Program and Health Professions Student Loan Program. We strongly support these provisions in S.2229. Because of the severe shortage of occupational therapy, physical therapy and speech-language pathology and audiology personnel, we further recommend that additional monies be set aside for occupational therapy, physical therapy and speech-language pathology and audiology either through bill language or strong Committee report language designating funding specifically for these three disciplines.

4. Which programs in Title VII should be eliminated because they do not address these needs?

A study of the history of the Title VII legislation reveals the emphasis placed on funding programs for training in medicine and dentistry in particular. Today, there exists a reported over supply of certain medical and dental specialties, while the literature notes severe shortages in the rehabilitation professions (see attached). We suggest therefore that modifications should be made to the funding priorities of those Title VII programs which would respond to the over and under supply of these health professions.

Again, we commend you for your continuing interest and concern on this issue. If you have any questions concerning this letter, please contact me (648-9300).

Sincerely,

Corrine Parver
Assistant Counsel

Enclosures

cc: Senator Orrin Hatch
Patrick Duarte
American Occupational Therapy Association
American Physical Therapy Association

Nursing shortages: just the tip of the iceberg?

The bad news is that in the year 2000 there will be an even bigger demand for allied health professionals. While enrollments in allied health educational programs should remain steady or drop, increased demand for physical therapists and radiological technologists—to give two examples—is projected to rise 87 percent and 65 percent, respectively, from 1986 to 2000. So says the U.S. Bureau of Labor Statistics.

The demand projections for most allied health professions are up, according to the bureau. Occupational therapist (OT) positions will grow tc 52 percent by the year 2000; physical therapy aide jobs (82 percent); lab technician/technologist (24 percent); pharmacist (24 percent).

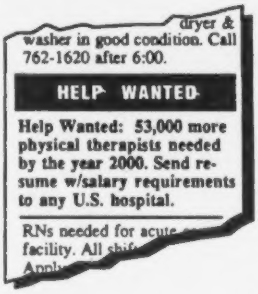
Shortages menacing. If these projections are correct, hospitals' shortages of allied health professionals could get a lot worse.

The problem *is* serious, even if the specific projections need to be taken with a grain of salt. If hospitals' shortages get worse, "we could be seeing only the tip of the iceberg" as far as staffing problems are concerned, says Phillips Kerr, vice-president of human resources at the Medical Center Hospital of Vermont, Burlington.

The shortage could breed more of the same: "Institutions may force staff to work short, then frustrated staff would quit, leaving health care because of the added pressure," Kerr explains.

However, the evidence of current allied health worker shortages is more anecdotal than statistical because the fragmented allied health care field isn't noted for statistical recordkeeping. The head of a school for medical technologists said he could have "placed his graduating class three times over," says a source at the American Medical Association.

In the absence of an economic recession, recruitment problems in allied health will remain and will grow, according to Anne Kahl, an economist in the Office of Economic Growth and Employment Projections, Bureau of Labor Statistics. By sending financially strapped people back into the workforce, a recession could make nursing shortages vanish, as it did in 1981, she maintains. Increased salaries and benefits would, of course, also draw more health professionals into hospitals, alleviating shortages.



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The victim: long-term care? The hardest hit will be long-term care providers, Kahl says. "Recruitment and retention problems are on the way for hospitals, but are already chronic with long-term care. Long-term care struggles to compete for labor because it isn't as financially rewarding or as professionally challenging as either hospitals or alternate care deliverers."

Statistics: the PT problem. The perceived institutional shortage of physical therapists (PTs) is real, says Kenneth Davis, director of the department of practice, American Physical Therapy Association, Alexandria, VA.

There's a net gain of 2,200 new PTs each year. The Bureau of Labor Statistics recently upped their predictions of increased demand for physical therapists. They project 53,000 new PT positions by the end of the century—or almost 4,000 new PT jobs per year. And that leaves a substantial shortage at present supply levels.

A Massachusetts survey published in 1987 found that PT vacancies were around 4 percent in private practice as well as rehab and chronic care hospitals, but acute care hospitals had a 10 percent vacancy level. Growth in the state's PT jobs was up 9.1 percent per year, compared with 1.5 percent for total health care positions.

Indications of shortages go on and on. The Veterans Administration claimed a 22.9 percent PT vacancy rate in 1986. A total of 113 VA facilities—80 percent of those responding to a survey—reported that quality of care has suffered because of similar shortages in OTs, according to the American Occupational Therapy Association, Rockville, MD.

The bright side. Putting the present shortages in a more positive light, the AMA says that—as with past shortages—educational institutions will be responsive to demand. With shorter training periods than dentistry and medicine, allied health professions can meet increased demand more quickly than medicine, says the AMA, which accredits many allied health educational programs.

According to the AMA, labor gluts and shortages are cyclic, and this one will prove no different.—*R.W.* ∎

ASAHP Study Foretells Serious Shortage of PT

The American Society of Allied Health Professionals (ASAHP) reported that a serious and intractable shortage of qualified health-care personnel is one of the most critical problems the health-care system must face in the years ahead.

ASAHP President Thomas Freeland explained that changes in delivery settings such as an increase in long-term care and home-care settings; reimbursement policies; and demographic changes, such as an increasing aging population will create additional demands for these health professionals.

In addition, an AIDS epidemic affecting 50,000 individuals; severe faculty shortages; and a lack of federal attention and financial support to allied health education also contribute to shortages in these professions.

Severe shortages will be particularly noticeable in the areas of occupational and physical therapy; audiology; speech and language pathology; radiological technology; laboratory technology; dietetics; dental hygiene; and medical records administration, according to ASAHP.

Dr. Edmund McTernan, immediate past president of ASAHP and Dean of the School of Allied Health Professions at the State University at Stony Brook, in Stony Brook, N.Y., explained the shortage problem.

McTernan pointed out that these professions have been populated primarily by women, who are now selecting other options for careers. Contributing further to the shortage problem is the fact that today's high school students represent the smallest resource pools of recent generations.

Dr. Algeania Freeman, ASAHP member and Dean of the School of Public and Allied Health at East Tennessee State University concurred with McTernan and cited yet another important challenge for ASAHP — recruiting appropriate levels of blacks and minorities in allied health professions.

"It is extremely alarming that while blacks account for 12.2 percent of the population in the U.S., they represent only six percent of the health-care work force," said Freeman. She explained that there continues to be a consistent decline in the number of black students who enter allied health education programs and noted that decreases in minority enrollment in these programs "appears to parallel the decline in the federal dollars supporting such programs."

In response to concerns by these and other deans from universities across the country, ASAHP reported that it will undertake a variety of educational and research initiatives. "As the recognized national coalition in allied health, we are examining the challenges of shortages in allied health personnel through conferences, publications, and a variety of marketing and research efforts," said ASAHP President Thomas E. Freeland. For example, to enhance the image of allied health professionals, ASAHP is hosting career awareness seminars for high school students and adults who are considering a career in allied health. The society is also sponsoring a variety of joint programs with related health associations in an effort to successfully market the allied health professions.

Freeland also reported that the association is involved in legislative and regulatory health policy issues affecting allied health and is working to secure federal funds for allied health professional training.

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Emergency Care Demand Blamed On Ice Skating

ULSTER, Northern Ireland — An ice rink in the vicinity of a hospital may impose a considerable strain on local accident and emergency deparments, according to Dr. P. Freeland of Ulster Hospital.

In the six months following the opening of an Olympic rink and a "family fun rink" in the area, 636 of the total 20,317 patients seen in the A and E department at Ulster Hospital had injuries sustained at the rinks.

Most of the 636 patients, aged five to 81 years, had been injured by direct contact with either ice or barriers at the rinks.

Knee and head bruises and wrist fractures were the most common injuries. Three percent of all ice rink injuries resulted in death (compared with 4 percent of all road accident victims), researchers said.

The risk of serious skating injuries is "considerable," said Dr. Freeland, and should be taken into account when new ice rinks are planned. He advised that skaters should wear protective clothing at the rinks, and that knee pads and helmets (the latter required for young skaters in Canada) would reduce a large number of skating injuries.

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Naples, Fla. 33942

Critical OT Shortage Predicted

Reports Growing Problem

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OT WEEK

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Lead Poisoning Remains Major Occupational Hazard

LOS ANGELES — More than 300 California workers had occupational exposures that raised their lead levels to potentially dangerous heights, according to a review of nine months of blood test results from labs throughout the state by the Occupational Health Surveillance and Evaluation Program.

Four out of five of the reported cases involved Los Angeles County residents, and 44 percent of those affected statewide were Latinos — more than double the proportion of Latinos in the state's population.

In one case described in the study, workers demolishing a bridge coated with lead paint were denied respirators. Of six workers on the job, three were hospitalized — one with a blood-lead level four times that considered potentially dangerous. Because lead accumulates in the body, extended exposure can damage the circulatory system, the central nervous system, the reproductive system, and the kidneys.

AMERICAN ASSOCIATION OF DENTAL SCHOOLS
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May 25, 1988

Senator Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
SD-428 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Kennedy:

Enclosed please find the responses to additional questions addressed to Stephen Wotman, DDS, MPH by Senator Orrin Hatch. Also enclosed is a copy of Dr. Wotman's testimony.

Sincerely,

India Owen

India Owen
Administrative Assistant

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HAYDEN G. BRYAN, MINORITY STAFF DIRECTOR

United States Senate
COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510

May 13, 1988

Stephen Wotman, D.D.S., MPH
Dean, School of Dentistry
Case Western Reserve University
2123 Abington Road
Cleveland, Ohio 44106

Dear Dr. Wotman:

I would like to thank you for testifying at the Health Professions Reauthorization hearing on April 28, 1988. As a follow up, the ranking minority member, Senator Orrin Hatch, has submmitted additional questions regarding this reauthorization. Your prompt response is greatly appreciated as the deadline for the hearing record is May 24, 1988.

If you have any questions please call Win Froelich (202-224-2094) or Stephen Keith (202-224-7675).

Sincerely,

Edward M. Kennedy

Edward M. Kennedy
Chairman

EMK/dr

Responses to questions from Senator Orrin G. Hatch (R-UT)

1. Could you please comment on what you see as the nation's major health manpower needs over the next three years?

The nation's most pressing health manpower needs concern: the availability of primary care, including general dentistry; training in geriatric medicine and dentistry; and increased understanding of patients with special needs -- including the handicapped, the medically compromised, and patients with AIDS. It is critical that access to a career in the health professions remain available to students from all walks of life and that special initiatives be undertaken to recruit underrepresented minorities into the health professions. Faculty creativity must be fostered to yield innovative new approaches to health professions education that will incorporate new technologies for all students and allow alternative programs for non-traditional students. Special attention should be given to enhancing access to care for those in rural areas, border areas, and other underserved areas of the country.

2. Which of the existing programs in Title VII best meet the needs you have identified?

General dentistry residencies; Geriatric education centers; the Geriatric training program; the new AIDS health professions education initiatives (as contained in S. 1220); the Disadvantaged Assistance program, including scholarships provided through the Financial Assistance to Disadvantaged Health Professions Students; Exceptional Financial Need scholarships; the Health Professions Student Loan program; Health Education Assistance Loans; Area Health Education Centers; Special Initiatives; and the proposed new Allied Health grants.

3. What changes should be made to Title VII to improve the ability to meet these needs?

A detailed account of changes recommended for Title VII is contained in the written testimony filed with the Committee on Labor and Human Resources by the American Association of Dental Schools (AADS) on April 26, 1989, an additional copy of which is attached.

4. Which programs in Title VII should be eliminated because they do not address these needs?

Rather than eliminating these much-needed programs, expansion and modification of Title VII, as detailed in the April 26, 1988 AADS testimony referenced above, would best promote the nation's major health manpower needs.

AMHPS

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Dale P. Dirks
President

May 23, 1988

Honorable Orrin Hatch
Committee on Labor and Human Resources
United States Senate
SH-835 Hart Senate Office Building
Washington, DC 20510

Dear Senator Hatch:

Thank you for requesting that we provide responses to your questions. I will respond to your questions in the order they were asked.

(Q) Could you please comment on what you see as the nation's major health manpower needs over the next three years?

(A) Despite the progress that peaked in the 1970's to increase the enrollment of minorities at health professions schools, there still remains a substantial gap in the percentage of blacks in the health professions, compared to the general population. This gap has been associated closely with the persistent health status gap that exists among blacks when compared to whites. As reported by the 1985 HHS Secretary's Task Force Report on Black and Minority Health, any increase in the percentage of blacks in the health professions would have a positive impact on the health status of blacks, an identified national priority. AMHPS believes there is still a severe shortage of blacks and other minorities in the health professions, and that there is a need to focus efforts on primary care specialties in all of these disciplines.

(Q) Which of the existing programs in Title VII best meet the needs you have identified?

(A) The Health Careers Opportunity program has significantly improved our ability to recruit, retain and train minorities in the health professions. We believe it is very valuable to foster an early, positive program of nurturing young promising students who demonstrate ability and interest in a health professions career. The H-COP program has helped us significantly.

For poor students who show promise, the Exceptional Need scholarship program has been very helpful in providing first year funding so a poor student gains confidence in their ability and career goals.

We expect that the Excellence in Minority Health Education and Care Act will prove an outstanding program at several of our schools. Centers grants under this program will utilize a multidisciplinary approach of learning resource enhancement, advanced remedial training, facility improvement, faculty enhancement, and other factors to improve the overall capability of several of our minority schools to train increased numbers of blacks and other minorities in medicine, dentistry, pharmacy, and veterinary medicine. Although the first centers grants have not yet been awarded, we expect that this program will have a positive impact on the number of minorities in the health professions.

(Q) What changes should be made to Title VII to improve the ability to meet these needs?

(A) Several improvements have been presented in the legislation now being considered by the Senate Labor and Human Resources Committee. Clearly, even though this nation is experiencing budget constraints, there must be a greater level of funding in each of these programs. Also, we support "performance clauses" proposed for the H-COP program by the legislation. We believe that if an institution cannot increase their minority enrollment, or maintain a significant minority enrollment, their H-COP resources would be put to better use at predominantly minority schools, or at schools that have a commitment to significantly increasing their minority enrollment.

Programs that provide resources for primary care training need to be increased in order to maintain and improve the current short supply of providers serving underserved areas.

(Q) Which programs in Title VII should be eliminated because they do not address these needs?

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(A) Each program in Title VII serves a significantly and important purpose. If anything, these programs should be significantly increased and improved rather than eliminated. Until there is a greater degree of health status/health professions parity, we should maintain and increase these important programs. While there are still manpower shortages in geographic and ethnic areas of the nation, clearly we should enhance our efforts.

Thank your for the opportunity to present the views of the Association of Minority Health Professions Schools. We look forward to working with you to enact Title VII legislation.

Sincerely,

Marcellus Grace

Marcellus Grace, Ph.D.
President

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May 23, 1988

The Honorable Edward M. Kennedy
Chairman, Committee on Labor
  and Human Resources
428 Dirksen Senate Office Bldg.
Washington, D.C.   20510

Dear Senator Kennedy:

Attached is my response to the additional questions you sent regarding the hearing on the Health Professions Reauthorization. I would also like to thank you for holding this hearing and the opportunity to testify on behalf of the American Academy of Family Physicians. As you and your staff are aware this is an important issue for the Academy.

Please don't hesitate to contact me again if you have any further questions.

Sincerely,

Andrew P. Morley, Jr., M.D.
Chairman, Board of Directors

APM/la

cc: Stephen Keith

1. Could you please comment on what you see as the nation's major health manpower needs over the next three years?

As is outlined in the preliminary report of the Council on Graduate Medical Education, the need to address the shortage of family physicians in this country is a priority. While some believe that nationally there is a surplus of physicians, it is clear that the problems of specialty and geographic maldistribution of physician services are not yet solved. To achieve the goal of access to health care by the American people, the supply of physicians must be appropriate to meet the demand. Because family physicians are well trained to care for people of all ages, they are in significant demand by the private sector as well as government programs, such as the National Health Service Corps. The supply of family physicians is limited for several reasons -- the leveling off in the number of family practice residency programs (paralleling the leveling off of federal support), the attrition from practice of those family physicians who are 55 and older (one third of family physicians), and the significant demand for family physicians in HMOs and other "managed care" systems. For these reasons, the American Academy of Family Physicians believes that a national priority in health manpower should be to train additional family physicians.

2. Which of the existing programs in Title VII best meet the needs you have identified?

Section 780 of Title VII, which provides grant support to departments of family medicine in medical schools has been instrumental in helping family medicine gain "equal footing" with other academic departments in some schools, and is continuing to strengthen the family medicine department in others. Exposure to family practice at the medical school level is particularly important in the decision of the medical student to choose family practice as his or her specialty. At a time when medical school debt is high, and reimbursement for family practice is low, exposure at the medical school level can counteract the many negative incentives for selecting the specialty of family practice.

Section 786 of this title is instrumental in providing grant support for residency programs and for faculty development to help maintain and improve programs. As outlined in testimony, family practice residency programs tend to be financially fragile, and have thrived in large measure due to the federal support under Section 786.

To sustain the gains that have been made in addressing specialty and geographic maldistribution of physician services, both Sections 780 and 786 need to be reauthorized.

3. What changes should be made to Title VII to improve the ability to meet these needs?

The only change to Sections 780 and 786 under Title VII we would advocate would be increased authorization levels. The basic authorities have been administered in an exemplary fashion by the Division of Medicine, Health

Resources and Services Administration. However, the limited funding available has limited the number of approved grants that can be funded. We would point out that the appropriations for both of these sections have consistently been at or near the levels authorized, and we believe that higher authorization levels therefore would be appropriate. Beyond increasing the authorization levels, we would recommend against any changes in the authorization language for either of these two important programs.

We would specifically recommend against increasing the percentage of Section 786 appropriations earmarked for general dentistry (currently 7.6 percent of amounts appropriated) at the expense of family practice.

4. Which programs in Title VII should be eliminated because they do not address these needs?

The American Academy of Family Physicians is particularly concerned that both Sections 780 and 786 be continued in their present form to continue to target family practice at both the medical school and residency level. The federal funds that have been appropriated to date have played a significant role in helping to address the problems of geographic and specialty maldistribution of physician services and we believe will continue to do so if given the opportunity.

AACOM

Chicago College of Osteopathic Medicine
College of Osteopathic Medicine of the Pacific
Kirksville College of Osteopathic Medicine
Michigan State University College of Osteopathic Medicine
University of New England College of Osteopathic Medicine
University of Medicine and Dentistry of New Jersey — School of Osteopathic Medicine
New York College of Osteopathic Medicine of New York Institute of Technology
Ohio University College of Osteopathic Medicine
The Oklahoma College of Osteopathic Medicine and Surgery
Philadelphia College of Osteopathic Medicine
Southeastern College of Osteopathic Medicine
Texas College of Osteopathic Medicine
The University of Health Sciences/College of Osteopathic Medicine
University of Osteopathic Medicine and Health Sciences
West Virginia School of Osteopathic Medicine

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April 29, 1988

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
SH527 Senate Hart Building
United States Senate
Washington, D. C. 20510

Dear Senator Kennedy:

The American Association of Colleges of Osteopathic Medicine is pleased to submit its views on S.2229, the "Health Professions Reauthorization Act of 1988". We request that our statement be made part of the Committee's official hearing record on this bill.

AACOM supports the reauthorization of these important programs of health professions educational assistance. We urge prompt Committee action on this legislation.

Sincerely,

Sherry Arnstein

Sherry R. Arnstein
Executive Director

AACOM

Chicago College of Osteopathic Medicine

College of Osteopathic Medicine of the Pacific

Kirksville College of Osteopathic Medicine

Michigan State University College of Osteopathic Medicine

University of New England College of Osteopathic Medicine

University of Medicine and Dentistry of New Jersey — School of Osteopathic Medicine

New York College of Osteopathic Medicine of New York Institute of Technology

Ohio University College of Osteopathic Medicine

The Oklahoma College of Osteopathic Medicine and Surgery

Philadelphia College of Osteopathic Medicine

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Texas College of Osteopathic Medicine

The University of Health Sciences College of Osteopathic Medicine

University of Osteopathic Medicine and Health Sciences

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STATEMENT OF

THE AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

TO THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

April 28, 1988

RE: REAUTHORIZATION OF HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE PROGRAMS
UNDER TITLE VII OF THE PUBLIC HEALTH SERVICE ACT; AND
S. 2229, THE "HEALTH PROFESSIONS REAUTHORIZATION ACT OF 1988"

The American Association of Colleges of Osteopathic Medicine (AACOM), representing the 15 colleges of osteopathic medicine, is pleased to present its views on the reauthorization of health professions educational assistance programs under Title VII of the Public Health Service Act, and on S. 2229, the "Health Professions Reauthorization Act of 1988."

It has been argued that many of these programs are no longer needed because of the oversupply of physicians. This is true for certain medical specialties and subspecialties, and some areas of the country are crowded with physicians. However, this is not the case in many parts of the country; for example, the rural and other underserved areas of America served by graduates of the colleges of osteopathic medicine. It is also not true that there are too many primary care physicians. More are needed. The health professions programs have been an important part of efforts to reduce these shortages. However, since medical manpower distribution problems still remain, it is clear that the work of the osteopathic medical schools and the federal government is far from completed. Programs of targeted support, like those under Title VII, are still very important. S. 2229 is an important step in the right direction to help meet these pressing needs.

Over the years, osteopathic medicine has been committed to providing primary medical care services and family physicians, especially to individuals who live in smaller communities. The majority of America's osteopathic physicians practice in one of the primary care disciplines, or in associated fields such as emergency medicine. About half of them are practicing in communities of under 50,000. Some osteopathic medical colleges, such as the Ohio University College of Osteopathic Medicine and the West Virginia School of Osteopathic Medicine were specifically charged by their state legislatures to train primary care osteopathic physicians to practice in the medically underserved areas in those states. While each of the 15 osteopathic medical colleges is unique, they are united in their desire to train physicians who are philosophically and educationally equipped to give total family medical care and who treat and understand the needs of the "whole" person.

Federal health professions grants over the years have enabled AACOM's members to build and expand their innovative training programs and have also enabled their students, who come from a variety of socioeconomic backgrounds, to have the opportunity to study osteopathic medicine and be educated as primary care, family doctors. For many years, the colleges have been fortunate to develop partnerships with state and federal government, as well as with private interests, to foster programs that further their missions of education and service.

These partnerships have also helped the schools provide extensive medical services to those in need in the communities where they are located. For example, federal family medicine grants assist the Chicago College of Osteopathic Medicine to support faculty and staff who work with students and patients in the College's extensive ambulatory clinics. In Des Moines, Iowa, the University of Osteopathic Medicine and Health Sciences has a broad-based program offering free medical care to unemployed people living in the Des Moines area. Here again, a family medicine grant helps support the staff in these clinics. The Ohio college is a partner in an Area Health

Education Center (AHEC) grant. This multi-disciplinary program has allowed the college to provide medical care to rural, underserved areas in southeastern Ohio, thus helping fulfill its legislative mandate.

Other colleges of osteopathic medicine have also used the AHEC program to reach throughout their states to provide medical services and health education. As an example, the College of Osteopathic Medicine of the Pacific in Pomona, California works through an AHEC to reach the Hispanic community in East Los Angeles in an effort to improve medical services there. The Southeastern College of Osteopathic Medicine in Florida uses an AHEC to provide medical services to migrant families. The Oklahoma College of Osteopathic Medicine and Surgery uses its AHEC grant to provide services to Native Americans and other ethnic minorities in the region. Oklahoma also runs an innovative program of health promotion and education in a low-income housing project as one part of its AHEC activities. The University of New England College of Osteopathic Medicine, the only medical school in Maine, uses an AHEC to help meet pressing medical needs in that largely rural state.

The colleges that participate in AHEC programs also use that network to provide continuing medical education to health professionals who live and practice in rural areas and smaller communities. This includes not only physicians, but also nurses and other allied health professionals who are working there. The Kirksville College of Osteopathic Medicine in Kirksville, Missouri, provides a variety of health services, as well as training to students, through rural satellite clinics in northeastern

Missouri. The Rural Health Initiative grant at Kirksville is one of the first ever in rural America serving uninsured farm families. Kirksville recently applied for an AHEC grant which, if approved, will be used to provide support for farm families facing economic crisis.

Many of the osteopathic medical colleges have used family medicine training grants to improve the quality of their family medicine programs. In California, a graduate training grant has permitted the college to expand the numbers of residency positions in family medicine. The college has also used a faculty development grant to improve the quality of teaching. At Michigan State University College of Osteopathic Medicine, federal funds in the family medicine program have been used to strengthen adjunct faculty involved in clinical training. Similar grants have contributed significantly to the quality of the family medicine program at the New York College of Osteopathic Medicine.

In all these examples, osteopathic medical students work in the settings as part of their clinical experience. Thus, they are exposed to the physician role models that encourage them to practice primary care. At the same time, they are learning medicine and providing services to patients. Thus, federal funds under Title VII of the Public Health Service Act not only expand their capacity to provide care to those who need it now, they also enlarge their capability to train new generations of primary care physicians so that the nation can be assured of meeting the medical needs of the future in these communities.

AACOM cites these examples in order to demonstrate as clearly as possible the connection between these programs that were authorized in Washington and the education and services provided at osteopathic medical colleges throughout the nation. For example, the Chicago college has a family medicine grant program that enables it to support rotations of medical students in rural Illinois. One concrete result of this program is that more osteopathic physicians are settling in rural parts of the state to practice. Further, a recent University of Wisconsin study on the supply of physicians in rural counties of Missouri showed that 73.7 percent of the counties were served by osteopathic physicians. There is no question that these health professions grants have helped osteopathic medical colleges enhance their ability to educate and to provide medical services. Their record of achievement demonstrates the wisdom of the Federal investment in these programs.

It is important to support institutions to enable them to improve the quality of their educational and service programs; yet, it is equally important that students from all economic and ethnic backgrounds have the opportunity to seek health professions education. The Health Careers Opportunity Program (HCOP) has played a critical and unique role in the identification, recruitment, and retention of minority students in health professions schools. AACOM is a major grantee under that program and works with a consortium of osteopathic medical colleges to encourage minority students to enter the health professions. Since 1982, approximately 67 percent of the students who have participated in the AACOM HCOP programs have applied to enter health professions schools. HCOP funds are also essential in efforts to retain minority students once they have enrolled.

Few health professions schools can come before Congress and argue that enough has been done in the recruitment of minority students for health careers. There are still many barriers that need to be overcome. The federal government must authorize more activity, not less, under the Health Careers Opportunity Program.

Very important components of Title VII are the Health Education Assistance Loans (HEAL) and the Health Professions Student Loans (HPSL) authorities. Without these programs, many students would not have the opportunity to achieve the professional education needed for health careers. This is particularly the case for osteopathic medicine. As mentioned earlier, the colleges in Kirksville, Missouri, Ohio, and West Virginia have special dedications to providing family physicians in those regions. Therefore, they seek students with an interest in providing medical care in rural communities. Often those students are from these same rural areas, and many do not have the personal or family resources to pay the cost of an osteopathic medical education. Many of the senior students report parental incomes of less than $10,000 and 40 percent come from families with income below $30,000. They must rely on financial assistance, much of it federal. The availability of a variety of federal student assistance programs has made it possible for the colleges to offer an education to a broad spectrum of students. These educational opportunities would evaporate for many without a continued federal commitment to student assistance.

The following statistics dramatize the dependence of osteopathic medical students on federal educational assistance. Tuition and living expenses at a private osteopathic medical college, such as Kirksville, can exceed $21,000 a year. At state schools, the average costs are not as high but still are about $10,000 for residents and over $12,000 for non-residents. Faced with these kinds of costs, 92 percent of the seniors in osteopathic medical colleges expect to graduate with sizeable debts from financing their education. In 1984, that debt averaged $40,000. For those students who will graduate in 1988, AACOM expects their indebtedness to average $61,000. This increase in debt results from two factors. First, education costs continue to rise despite efforts by schools to hold tuition down. Kirksville, for example, had not increased its tuition in four years. The second reason is that scholarship funds, such as the National Health Service Corps scholarship, have practically disappeared. Thus, students have become increasingly dependent on loan programs to finance their education. AACOM has noticed increases in the neighborhood of 16 percent from one year to the next in the total number of loans taken out.

AACOM realizes that the HEAL program is viewed by the government as a loan of last resort. However, as the scholarship monies and other resources have become more scarce, HEAL loans have become increasingly important to health professions students. Approximately 25 percent of osteopathic medical students' loan funds come from the HEAL program. This is taking place despite the fact that HEAL repayment can be quite a burden because of high interest rates. This problem is compounded by the Tax Reform Act of 1986 which eliminated the deduction for interest for these loans. AACOM is

1986 which eliminated the deduction for interest for these loans. AACOM is extremely concerned over the impact this will have not only on the career choices of the students but also on their ability to repay. The HEAL default rate of osteopathic medical students is among the lowest of all health professions. This is a record AACOM hopes will continue, but a variety of pressures may make that harder to maintain. AACOM believes that the deductability of interest on student loans should be restored.

The main goal of the colleges of osteopathic medicine is to train physicians to provide comprehensive family health services to those in need and to provide these services in geographic areas of the country where the need is greatest. The federal government, working through these grant and student assistance programs, has been an important part of that effort. The programs discussed here have contributed in a major way to this success, but more work must be done. There are still parts of the country with acute medical service needs and there are still needs for primary care physicians. There are still students who want to help meet these needs, but they require financial assistance in order to do so.

AACOM urges a continuing and strengthening of the programs under Title VII. There are a few key recommendations that AACOM would like to make for the consideration of the Committee.

The Area Health Education Center (AHEC) program is an important federal initiative. One of the great problems with the distribution of physicians in many rural areas is that physicians can become isolated, personally and professionally, from their peers. This makes rural practice less attractive. The AHEC program can serve as a bridge between the isolated practitioner in a small community and centers of medical excellence. It is a perfect vehicle for continuing medical education for physicians and other health professionals.

It is also an effective mechanism for helping to address changing community needs. For example, southern California experienced a tremendous influx of Hispanic and Oriental populations that have visibly altered the communities in which they live. The AHEC can serve as a way of reaching out to those populations because of the close community ties that AHECs must build.

AACOM recommends that the Subcommittee increase the authorization for AHECs. Appropriations have been at the $18 million ceiling that is now authorized, and these programs are valuable enough to have the addition of $5,000,000 in authorization. There are still states that do not have AHECs which could benefit greatly from them. There are still populations, such as Hispanics in many of the border states or Caribbean island refugees in Florida, for whom routine access to health care is still a problem. A system must exist to bridge those gaps, and a larger AHEC commitment can help accomplish that.

There is a continuing need to be able to train medical students and residents in community settings. Expansion of the AHEC, in conjunction with family medicine training programs, could help meet that pressing need.

Osteopathic medicine stresses an educational model that places students and interns in rotating experiences in community hospitals and physicians' offices. The AHEC can support those educational experiences.

AACOM also recommends that the funding cycle be modified. Right now there is a limit to the number of years the federal government will participate in an AHEC. It is important for states and communities to join the federal government in supporting an AHEC; however, modifications of that funding pattern may sometimes be appropriate. For example, if anticipated state funding does not materialize because of an economic downturn in the state, it would be extremely important if the Department of Health and Human Services had greater latitude in the length of time that it could fund the program. In such a circumstance, it would be appropriate to extend the federal presence for another two to three years until circumstances change and state funding could be restored.

AACOM also believes that changing circumstances in a state or community served by an AHEC might call for an extended federal involvement. For example, the presence of AIDS has dramatically altered the health picture in many parts of the country, and AHECs should be able to work with the federal government for a longer period of time to help address these changes in community need. Special project funds could be enlarged in order to meet these requirements.

It is well recognized, both by many Members of Congress and by other health policy experts, that more primary care physicians need to be trained.

To do so, there must be sufficient numbers of post-graduate training programs available not only in hospitals, but also in the community and in physicians' offices. The rural hospital system is dying and in need of urgent support. AACOM recommends an expansion of the family medicine training programs, particularly residency positions, with emphasis on ambulatory care sites.

Faculty development grants are also very important. Not every physician is a born teacher and often the schools must work with adjunct faculty to strengthen their teaching skills to enable them to teach and guide students, interns and residents. AACOM would like to be able to expand the opportunities for osteopathic medical students to learn their family medicine in community settings and needs physicians with good teaching skills to do that. Federal funds are essential to ensure that students, interns, and residents receive the optional benefit from such educational experiences.

An extremely important component of family medicine, and one in which osteopathic physicians are very much interested, is geriatrics. There has been a renewed emphasis on geriatrics under Title VII, and AACOM urges that this program continue and be better integrated into both the AHEC program and the family medicine training program. Family physicians must understand the needs of, and treat, patients of all ages. Osteopathic physicians, since they practice in many smaller communities, often have a large elderly population in their practice. The nation needs to better prepare its family physicians to deal with the "graying of America." As educators of osteopathic physicians, the colleges want to strengthen their ability to train them in geriatrics. AACOM urges more emphasis on that area in the reauthorization of Title VII.

As already mentioned, a disease can dramatically alter the medical needs of a community. AIDS is one such disease. It is extremely important that health professionals be better trained to deal with AIDS patients. Much of the management of an AIDS patient is handled by primary care physicians. AACOM recommends using the AHEC program as a vehicle for AIDS continuing medical education for family physicians. This is important not only in teaching these health professionals how to deal with the patients, but also in teaching them how to protect themselves from inadvertent exposure to the disease. AACOM does not want to see physicians abandon AIDS patients out of fear. Therefore, it is incumbent to find ways to better educate them about the risks and how to minimize them. These federal programs--AHEC and family medicine training grants--can be vehicles for providing this education first to students, interns, and residents and then to practitioners in the community. Further, because of the colleges' experience with the AHEC program in reaching out to high-risk communities, such as families living in housing projects, AACOM believes that the AHEC, in conjunction with other agencies, can be an effective vehicle in certain circumstances to convey education to the public.

Physicians also need to become more expert at educating and counseling their patients, especially teenagers and young adults whose behavior may place them at high risk. This responsibility is not limited to family practitioners, but rests with many specialties. These skills need to be learned in medical school and reinforced in internship, residency, and daily practice. Because of the unique nature of AIDS and the sensitivities of counseling, AACOM urges the creation of a new grant program that will enable health professions schools to set up special programs to teach these skills.

The final set of recommendations relate to the student assistance programs. First, AACOM strongly urges that the HPSL program receive additional funds. This is a very useful loan program, and renewed emphasis should be placed on it in order that more students not be forced into the HEAL program with its much higher interest rates. S. 2229 is responsive to this concern.

Also under HPSL, there appears to be a problem with verification of parental income. Many students in osteopathic medicine are older and are very uncomfortable asking their parents for financial information. The parent financial information requirement for HPSL should be waived once a student reaches a certain age and declares independence.

The HEAL program is increasingly used by osteopathic medical students. Because of the size of the program and the large interest rates, defaults are a major concern of the federal government. AACOM shares in this concern, but hopes that the desire of Congress and the Department of Health and Human Services to limit defaults will not lead to situations in which it becomes more difficult for osteopathic medical students to obtain financing. Concerns have already been expressed by financial aid directors at several of the colleges over problems facing married students who are no longer able to figure all their expenses into the student budget. Since many of these students are older, they have families. This has become an issue, particularly at the college at Kirksville where jobs for spouses are not plentiful. AACOM hopes very much that during the course of the reauthorization, the Committee can find some way to ease this problem for these students.

The Administration's budgets have proposed major reductions in the level of HEAL guarantees. AACOM urges Congress to reject those cuts and to keep funding levels sufficiently high to meet student borrowing needs. The levels in S. 2229 are adequate for student needs.

AACOM also asks that legislative language be included that permits HHS to apportion HEAL funds on a schedule consistent with the needs of student borrowers. The Office of Management and Budget requires a quarterly apportionment. This timing is inconsistent with the educational schedule and HHS should be permitted to parcel out money when borrowers need it.

The Exceptional Financial Need Scholarships play a major role in helping provide educational opportunities for disadvantaged students. This program should have greater flexibility in the distribution of funds so that more than one student could receive assistance. If financial aid directors are permitted more flexibility, they could provide greater educational opportunities to more disadvantaged students.

It is very expensive to become an physician today. That cost is essentially the same whether one becomes a family practitioner or a neurosurgeon. However, the earning potential of the neurosurgeon is generally much higher than that of the family physician, thus the burden of repayment of student loans may be easier for the higher paid specialist. Osteopathic medical education is committed to developing family physicians and encouraging them to practice in smaller communities. AACOM is concerned, however, that people who would like to enter family medicine practice in smaller communities will be deterred because of the difficulty they would face meeting their loan obligations. Therefore, AACOM recommends that the Committee consider expanding the loan repayment concept to include individuals who enter family practice and also to include individuals who enter careers in teaching and research. All three areas have lower than average pay in the medical profession and many people are discouraged from taking those positions because it is harder for them to meet their loan obligations. A loan repayment program geared toward research, teaching, and family medicine would help overcome imbalances in all three areas.

This concludes AACOM's recommendations on the priority programs for osteopathic medical education under Title VII. S. 2229 addresses many of the issues appropriately and is supported by the osteopathic medical colleges.

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Statement on

REAUTHORIZATION OF TITLE VII OF THE PUBLIC HEALTH SERVICE ACT

S. 2229, THE HEALTH PROFESSIONS REAUTHORIZATION ACT

SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

Submitted by

Roger P. Kingsley, Ph.D.
Director, Congressional Relations Division
Governmental Affairs Department
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April 28, 1988

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Introduction: The Profession of Speech-Language Pathology and Audiology

Speech-language pathologists and audiologists are health, rehabilitation and education professionals who specialize in the identification, assessment and treatment of persons with communication disorders. Speech-language pathologists are specialists in the understanding and expression of human communication and its normal development; and in its disorders and the prevention of disorders, such as articulation, voice, fluency, auditory and/or visual processing and memory. They also are qualified to determine the need for augmentative communication devices and to provide individuals with training in the use of such devices. Audiologists are specialists in the prevention, identification, and assessment of hearing impairments, and in the habilitation and rehabilitation of persons with hearing impairments, including the fitting and dispensing of hearing aids.

Speech-language pathologists and audiologists provide services to individuals with communication disorders resulting from congenital disorders (such as deafness in children), stroke (resulting in aphasia), cerebral palsy and Parkinson's disease (resulting in oral-motor dysfunction), Alzheimer's disease (a principal cause of dementia), laryngeal cancer (resulting in laryngectomy), learning disabilities, head injury, and noise-induced hearing loss. Children, adults, and elderly persons with severe disabilities and mental retardation and related communication disorders can benefit from rehabilitative services provided by speech-language pathologists and audiologists.

Standards and Credentials in the Profession

The American Speech-Language-Hearing Association (ASHA), with over 56,000 members, is the national organization that establishes standards for individual practice, training and service programs in the field of speech-language pathology and audiology. ASHA awards the Certificate of Clinical Competence (CCC) to individuals with a master's degree who have completed a year of supervised clinical training and passed a national examination. The CCC is the standard recognized by Medicare, Medicaid, the Rehabilitation Services Administration and other federal agencies, as well as by private insurance plans. Thirty-seven states have licensure laws in speech-language pathology and audiology and the requirements are generally similar to the CCC. There are over 240 graduate training programs in the field, the majority of which are accredited by the Educational Standards Board (ESB) of ASHA. The ESB sets national standards for graduate education that are recognized by the U.S. Department of Education.

Prevalence, Shortages and Demands in Speech, Language and Hearing Services

Taken as a whole, the prevalence of disorders of communication form the largest disability category in the United States. The prevalence of hearing loss, according to the Health Interview Survey (1982) has been estimated to be 8.8% of the civilian non-institutionalized population or 19.7 million Americans.[1] Hearing loss is most common among the elderly, with one out of every four people over the age of 65 suffering from a hearing disorder. Speech and language impairments, are most common among children and make up the second largest category of disabilities in the public schools. It is estimated that speech disorders are present in 4.2% of the population -- approximately 10 million people.[2]

For the rest of this century and beyond, the numbers of persons with communication disorders will increase at faster rates than the total population. This trend results from the disproportionate growth in the elderly population, an increase in the number of surviving infants with disabilities, and an increase in the survival of individuals with communication disorders resulting from accidents (e.g., head injuries) and diseases. The percentages of speech and hearing impaired persons aged 65 and over were 20% and 43% respectively in 1980, but will grow to 25% and 46% by the year 2000, and to 39% and 59% by the year 2050.[3] As the communicatively handicapped population increases, so does the demand for qualified speech-language pathologists and audiologists to provide health care services.

The supply of speech-language-hearing personnel in this country has been steadily increasing and this trend is expected to continue. Taking into account an estimate of the number of non-ASHA members in the field, a figure of 86,700 speech-language-hearing personnel is arrived at.[4] With this workforce, the ratio of personnel-to-communicatively impaired population nationally is 1:280 which represents is a shortage from a "need" perspective. The proportion of ASHA members in health settings has doubled in the last 20 years and, when secondary employment settings are accounted for, these individuals make up 27.5 % of the membership.[5] This growth has been spurred by an increase in demand for speech-language pathologists and audiologists in hospital and rehabilitation settings. Education of children with communication disorders remains the largest area of services in the field, but there continues to be a demand for more school-based speech-language pathologists and audiologists.

Personnel Available and Needed to Serve Elderly People with Communication Disorders

As the number of older Americans continues to grow, health care services and qualified personnel to provide these services must also necessarily increase. The need for professionals to provide services to the communicatively impaired elderly must take into account the prevalence of speech, language and hearing disorders, population size, practice settings and delivery systems.

Because of changing demographics in the elderly population and the dynamics of the health care system, the actual number of speech-language-hearing personnel that will be needed to provide services to the elderly can only be estimated. Work force projections can be made by examining the numbers of students entering and graduating from training programs and by examining changes in the supply of professionals providing services. The number of master's degree entrants into the profession has declined by 1.5% over the past five years. Since this group provides the majority of clinical services, an inadequate influx of new professionals will be available for service to elderly persons with communication disorders. Also, the profession is experiencing a serious drop in the number of doctoral degree students.[6] Since this group forms the majority of faculty members involved in personnel preparation programs, fewer will be available to teach incoming students.

Currently, ASHA surveys indicate that approximately 13% of the caseloads of speech-language pathologists and 32 % of the caseloads of audiologists consist of elderly individuals.[7] In a new report, Personnel for Health Needs of the Elderly Through the Year 2020, the National Institute on Aging projects significant increases in the number of professionals needed to provide services to older Americans with communication disorders. Based on current practice patterns and trends, by the year 2000, it is projected that about 11,000 full time speech-language pathologists and more than 8,000 audiologists will be needed to serve this population. As a result of the aging of the population and the disproportionate increase in elderly persons with communication handicaps, these figures continue to grow in the next century. The NIA study projects that between 15,800 and 23,700 full time speech-language pathologists and between 11,800 and 17,700 full time audiologists will be needed to work with elderly individuals by the year 2020.[8]

Minority Personnel in the Field of Speech-Language Pathology and Audiology[9]

We are pleased that the Committee bill emphasizes the training of more minority health care professionals. As Senator Kennedy pointed out in his introductory statement for S. 2229:

> Even though great strides have been made, our health professions schools need to increase the enrollment of these students to levels equal to their representation in the general population. Equal opportunities to enter the health professions need to be available to all our citizens.

The undersupply of minority professionals in the field of speech-language pathology and audiology is a serious problem. Over the past 15 years, there has been a small but steady increase in the proportion of minority members of the profession, from 1% to 4%. However, this figure is far below the minority population in the United States -- approximately 17% in the 1980 census.

As a subgroup within the profession, racial/ethnic minority members closely resemble the overall membership of the American Speech-Language-

Hearing Association. One notable difference is in the attainment of doctoral degrees, which is highest among minorities. Of all male ASHA members, Asians have the highest percentage of doctorates (47.6%), followed by blacks with 44.8%. By comparison, 38.2% of white males in ASHA hold doctorates. Black females have the highest proportion of doctorates (10.5%), followed by Asians (6.3%), and whites (4.2%).

Most of the 240 graduate training programs in the profession have small minority enrollments but are actively involved in minority student recruitment efforts. Of concern, however, is the overall downward trend in minority enrollment during the past five years. The decline was most precipitous in the 1982-1984 period and since then there has been a modest reversal. Minority enrollment in master's and doctoral degree programs has risen, but it has declined among undergraduates. Of further concern is the problem of student retention, for which precise figures in the profession are not known, but may be presumed to fit national trends which are not encouraging.

Overall, the occupations with the lowest number of minority students tend to be those that require more extensive training, advanced professional degrees, and/or specialized certification or licensure. Such requirements often pose barriers to entry at both the educational and professional levels. Financial constraint is the primary factor affecting retention of minority students in speech-language pathology and audiology programs.[10] The decline in federal student assistance, new tax laws affecting student financial aid, and the constantly increasing costs of higher education, often turn the "open door" of education into a "revolving door." Another significant barrier to minority student entry into the profession is the paucity of minority faculty in communication sciences and disorders programs. The Council of Graduate

Programs in Speech-Language Pathology and Audiology reported that minority faculty representation was only 5.7% of the academic and clinical faculty in graduate programs during the 1986-1987 academic year.[11]

Conclusion and Recommendations

Prevalence data concerning the communicatively impaired population and projections of increases in this population, combined with existing and projected personnel shortages relative to need, lead to the conclusion that a greater public commitment must be made to ensure that an adequate supply of qualified personnel is available to serve people with speech, language and hearing disorders.

ASHA is a member of the American Society of Allied Health Professions (ASAHP) and endorses recommendations made by that organization relative to the reauthorization of Title VII of the Public Health Service Act. We concur with ASAHP that

> A bold, new federal initiative must be advanced to address the shortages in allied health personnel predicted not only to intensify for the remainder of this decade and through the year 2000, but also to have a severe negative impact on the quality of care for an aging population.[12]

Specific recommendations include:

o Assistance targeted to allied health schools, private non-profit organizations, and public agencies to develop and expand career development and recruitment programs, including those for disadvantaged students.

o For Section 797, Traineeships for Advanced Training of Allied Health Personnel, we recommend authorization levels of: $6.5 million for FY 1989, $9.5 million for FY 1990, and $12.5 million for FY 1991. These levels are slightly higher than those contained in S. 2229.

o Section 787, the principal part of Title VII for assisting students from disadvantaged backgrounds, should be modified to authorize that 30% of the grants be awarded to allied health professions in order to increase the numbers of minority and disadvantaged individuals pursuing careers in allied health fields. We commend the Committee for including a substantial increase in overall funding levels for Section 787 and for making schools of allied health eligible for these funds.

o New doctoral programs in the allied health professions should be developed and existing programs strengthened and expanded. Priorities should be given to programs with severe shortages as well as those which focus on training of personnel to work with the elderly. As noted, there has been a serious decline in doctoral level enrollment in speech-language pathology and audiology.

o Special projects to expand and improve educational programs and services, including: (a) programs to expand the knowledge base in disease prevention and health promotion, gerontology and geriatrics, long-term care and home health care; (b) interdisciplinary programs involving professions which work with the same populations of patients (e.g., aging, disabled); and (c) demonstration projects which emphasize innovative programs linking clinical practice, education and research in allied health with patient care.

o For these special projects, we support the ASAHP recommended authorization levels of $5.5 million for FY 1989, $6 million for FY 1990, and $6.5 million for FY 1991.

o We also support the ASAHP proposal for A National Data Base on Allied Health Professions. We are pleased that the Committee has included such a system in its bill. This uniform health professions data reporting system would be established to collect, compile, and analyze data on allied health professions personnel. "Data shall include the most current information concerning the supply, distribution, and utilization of allied health practitioners and faculty, including physical therapy, occupational therapy, respiratory therapy, speech pathology, and audiology..."

Finally, we refer the Committee to a joint statement submitted by ASHA along with the American Occupational Therapy Association, the American Physical Therapy Association, the National Easter Seal Society, the National Association of Rehabilitation Facilities, and the American Hospital Association. We request that the Committee give serious consideration to the recommendation of a new authorization for programs to train rehabilitation professionals in the fields of physical therapy, occupational therapy, speech-language pathology and audiology.

NOTES

1. 1982 Health Interview Survey, Department of Health and Human Services -- National Center for Health Statistics (1985).

2. Fein, David J., "The Prevalence of Speech and Language Impairments," *Asha*, (25 February 1983), p. 37.

3. Fein, David J., "Projections of Hearing and Speech Impairments to 2050," *Asha*, 25 (November 1983), p. 31.

4. Shewan, Cynthia M., "The Current Supply of Speech-Language-Hearing Professionals: How Many Are Out There?," *Asha*, 30 (February 1988), p. 43.

5. Shewan, Cynthia M., "Speech-Language-Hearing Personnel in Rehabilitation Facilities," American Speech-Language-Hearing Association (October 1987), pp. 3-5.

6. Council of Graduate Programs in Communication Sciences and Disorders, *1986-87 National Survey* (October 1987).

7. American Speech-Language-Hearing Association, "Omnibus Survey" (1986).

8. National Institute on Aging, *Personnel for Health Needs of the Elderly Through the Year 2020*, National Institutes on Health (September 1987), pp. 81-82.

9. Information and data in this part are drawn from Lorraine Cole, "Minority Brain Drain in Human Communication Sciences and Disorders," American Speech-Language-Hearing Association (1987).

10. Cole, Lorraine and Massey, April., "Minority Student Enrollment in Higher Education Institutions with Communicative Disorders Programs, *Asha*, 27 (June 1985), pp. 33-34.

11. Council of Graduate Programs in Communication Sciences and Disorders, *1986-87 National Survey* (October 1987). Figure is based on 95% of programs reporting. With 100% reporting, the figure rises to 6%.

12. "Recommendations of the American Society of Allied Health Professions on the Health Professions Reauthorization Act of 1988 -- Title VII of the Public Health Service Act (February 1988), p. 4.

Statement
of the
AMERICAN ASSOCIATION OF COLLEGES OF PODIATRIC MEDICINE
on the
Reauthorization of Title VII of the Public Health Service Act
before the
Committee on Labor and Human Resources
Presented by

Anthony McNevin
April 28, 1988

Mr. Chairman and members of the Subcommittee-

My name is Anthony McNevin and I am President of the American Association of Colleges of Podiatric Medicine, a nonprofit educational association.

The Association represents the Nation's seven colleges of podiatric medicine, the 232 affiliated public and private teaching hospitals with fourth-year externship and residency training programs, and 3,000 students and 550 residents. It also represents a growing number of continuing education programs approved by the Council on Podiatric Medical Education, with participants in each program ranging from 20 to 300 podiatrists.

Background

As you know, Mr. Chairman, podiatric medicine is that profession which deals with the diagnosis, treatment, and prevention of diseases and disorders affecting the lower extremity.

Since the start of this century, science and technology have combined to help us develop a far better understanding of the foot, how it works, and what can go wrong.

Science has determined, for example, that our feet absorb the impact of up to half a ton of force every day, and that in the average lifetime our feet carry us an average of 100,000 miles. All of this activity is dependent upon one relatively small area that contains one-fourth of all the bones in our body, 19 muscles, and 107 ligaments.

The truth of the matter is that we pay little attention to our feet -- until something goes wrong. That something may be the result of a simple strain or hairline fracture, or it could be the early warning signs of more serious disorders affecting the body, such as heart disease, diabetes, arthritis, and musculoskeletal disorders.

Who is at risk?

Mr. Chairman, whether the result of a disease, a job-related accident, or a sports injury, all of us -- young and old -- are vulnerable to foot ailments.

We know, for example, that as many as ten percent of all children suffer from congenital foot problems that can curtail their activities and hamper both their physical and emotional development.

At the other end of the spectrum, we recognize that the fastest growing segment of our population also happens to be the group most at risk. As I am sure you are aware, the over-65 population will increase nearly 40 percent by the year 2000; within fifty years, that age group will double, with the greatest increase occurring in the oldest of the old, the over-85 age group.

For the elderly, untreated foot problems can mean the difference between leading independent, productive lives or years of limited mobility, pain, and anxiety.

Today, an estimated 95 percent of elderly Americans suffer from foot disorders and, according to the National Center for Health Statistics, one-fourth of all nursing home residents cannot walk as a result of foot problems.

Mr. Chairman, unless there is an adequate supply of podiatrists to meet their needs, many of the elderly will be forced to postpone or forgo treatment altogether -- only to require more extensive and more expensive health care later in life.

For these individuals, foot problems will rob them of the rewards that a lifetime of labor deserves.

What is being done?

It is clear to us that scientific advances and new medical and surgical techniques will count for little if we lack the resources to put our new-found knowledge into practice.

Our colleges recognize that fact and are striving hard to prepare well-trained individuals for the profession. As a result of our efforts, the number of graduates has steadily increased over the past two decades. In fact, during the period 1976 to 1986 first-year enrollments increased by 45.7 percent -- with minority enrollments showing the most dramatic increase, over 220 percent.

But despite this remarkable growth rate, there are still only (9,700) practicing podiatrists in this country, or about one podiatrist for every 25,000 Americans. And although the number of podiatrists has increased in recent years, the U.S. Public Health Service still characterizes this as "the profession with the most serious geographic distribution problem."

What challenges remain?

The problems of supply and distribution affect us all, Mr. Chairman. But the hardest-hit are the elderly and those who reside in underserved urban and rural communities.

Mr. Chairman, problems such as this are perhaps the most threatening breach in our health defenses. For as you know, our health as a Nation can be no better than the knowledge and skills of the health professionals to whom we entrust it.

Our colleges will continue to strive towards a solution to the problems I have outlined. But we cannot do it alone. These are national problems and they require a national effort. Under the cicumstances, we believe that the Administration's repeated attempts to eliminate or severely limit support for health professions is both short-sighted and misguided.

What is needed is prompt and vigorous action, not retrenchment.

Legislative Recommendations

Our Association urges the Subcommittee to reject the Administration's proposals to drastically limit support for health professions training, including the proposed cutback in support for the HEAL loan program. We also recommend that the following be included in the Subcommittee's reauthorization bill.

1. Primary Care Initiative. An estimated 70 percent of the Nation's podiatric physicians have clinical privileges in one or more hospitals; approximately 60 percent of these individuals can perform surgery on an inpatient basis. But the fact is that 90 to 95 percent of all podiatric care in the U.S. is rendered outside the hospital setting. The challenge now facing our colleges is to offer the specialized education and training required to practice comprehensive, podiatric primary care.

Recommendation: To that end, the Association urges the inclusion of a new primary care demonstration authority to support pre- and post-doctoral training projects, as well as traineeship and fellowships. We recommend that authorizations for this new initiative be set at $1.1 million in FY1989, $1.8 million in FY1990, and $2.5 million in FY1991.

2. Remote Site Training. Responding to the special needs of those living in medically underserved areas, Congress in 1984 authorized the establishment of a Remote Site Training program to (1) recruit and retain students who reside in shortage areas and (2) operate clinical training programs in or near such areas. To date, an estimated 260 individuals have participated in the program.

Recommendation: Our Association urges the Subcommittee to continue this authority through FY1991.

3. Geriatric Training. The incidence and prevalence of foot problems among the elderly is extremely high. In order to better prepare doctors of podiatric medicine to care for the burgeoning elderly population, faculty and residents should be afforded access and full participation in geriatric training programs.

Recommendation: Our Association urges the Subcommittee to adopt the amendments to section 788, as passed by the Senate earlier this year (S.1968).

4. Council on Graduate Medical Education. Section 799 authorizes establishment of the Council on Graduate Medical Education (COGME) to advise the Secretary and Congress on policies affecting graduate level education and training.

Recommendation: We urge the Subcommittee to expand COGME's membership to include a representative from the podiatric medical education community.

Thank you for the opportunity to submit this statement, Mr. Chairman. As always, we stand ready to assist the Subcommittee in whatever way we can.

THE COMMENTS

of the

AMERICAN SOCIETY FOR MEDICAL TECHNOLOGY

before the

Senate Committee on Labor and Human Resources

of the

UNITED STATES SENATE

on

S.2229, THE HEALTH PROFESSIONS REAUTHORIZATION ACT OF 1988

April 26, 1988

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The American Society for Medical Technology (ASMT) is pleased to submit comments on S. 2229, The Health Professions Reauthorization Act of 1988.

ASMT is the nation's oldest and largest non-registry national professional association for non-physician clinical laboratory professionals. Our more than 20,000 members include clinical laboratory directors, managers, administrators and supervisors, as well as staff practitioners at all levels of practice. Over 85% of our members possess at least a baccalaureate degree and many of the remainder are students. In addition to practicing in all types of clinical settings, ASMT members practice as research scientists; as consultants to physician office laboratories and independent laboratories; as educators and deans of allied health; as health policy analysts and as professionals engaged in developing and marketing clinical laboratory diagnostic equipment and products.

ASMT has established that clinical laboratory science is a profession that is distinct from the practice of medicine, characterized by its own, internally-defined Body of Knowledge and Scope of Practice, which requires from its practitioners competency in scientific, technical, managerial and scholarly principles and high standards of achievement and professional conduct.

As with any other profession, one of ASMT's primary concerns is to assure competency of its entry level practitioners, through a broad based educational program which integrates didactic learning with clinical experience. Educational programs should provide curricula which prepare students for their future roles in multiple laboratory settings. They also should facilitate upward mobility both within the clinical laboratory setting, and the educational arena.

A. S.2229 recognizes critical shortages in the profession and grants assistance to educational and other institutions to recruit qualified individuals and to increase program enrollments.

One of the major problems faced by the profession today is that the growing shortage of qualified clinical laboratory scientists will likely become a supply crisis within the next decade. Increased utilization of clinical laboratory scientists in non-traditional settings, coupled with the graying of America has substantially increased demand. However, mitigating factors such as skyrocketing educational costs, dissatisfaction with the profession due to inadequate salaries and lack of career mobility, and the perceived threat of AIDS, has seriously decreased the supply of clinical laboratory scientists.

Since 1983 there has been a 35% decrease in the number of medical technology programs. Additionally, there has been a dramatic decrease in class size. A recent CAHEA survey cites the average decrease in enrollment in clinical laboratory science programs as one student per program per year. Laboratory Medicine, Vol. 18 No. 7, July 7, 1987 "Survey of Educational Programs". It is widely recognized that Medical Technology is viewed by allied health students as one of the least desirable professions to enter into. ASMT, recognizing this potential crisis, has recently undertaken a major project to increase recruitment through publication of career information materials and dissemination of information about the profession at the secondary and collegiate levels.

Recruitment efforts must also be undertaken by educational and other institutions that offer programs in clinical laboratory science. Federal initiatives, such as those contained in Sec. 403 of S.2229, would encourage institutions to increase recruitment of clinical laboratory scientists, and improve and expand enrollment in clinical laboratory programs. Both private and public consumers of healthcare will surely suffer if the predicted shortage of clinical laboratory scientists is not halted within the immediate future.

B. ASMT supports the eligibility of allied health students for federal student loan assistance.

ASMT is pleased that S.2229 recognizes the severe financial stress placed on allied health students as a result of skyrocketing educational costs and decreasing student aid. Tuition costs for clinical laboratory science programs have more than doubled in the past decade. It is essential that allied health students have equal access to federal student loans.

ASMT supports funding for all quality programs leading to a baccalaureate degree in clinical laboratory science that comply with the National Accrediting Agency for Clinical Laboratory Sciences (NAACLS) 1986 Essentials and Guidelines of Accredited Educational Programs in Histotechnology.

We support Sec. 106 of the Bill, which for the first time gives clinical laboratory science students access to the much coveted Health Profession Student Loan program. We further support the continuation of the availability of Health Career Opportunity Program Grants to all institutions offering programs in clinical laboratory science.

C. ASMT supports increased assistance for training programs at the graduate level.

ASMT sees a critical need to develop and expand graduate and post-doctoral programs for clinical laboratory scientists. Few programs currently exist; thus, most of the more promising individuals in the professions seek alternative career paths. The future of the profession resides in our ability to attract qualified graduate students to conduct clinical/applied research to expand the body of knowledge in the profession; serve as faculty in clinical laboratory science programs; develop new technologies and methods of testing to improve the quality of patient care and the cost effectiveness of laboratory practice; and to direct and control the diagnostic and administrative functions of clinical laboratory services.

Graduate programs in clinical laboratory sciences are much more expensive to operate than graduate programs in other non-health related disciplines. College and university administrators frequently face difficult decisions funding clinical laboratory science programs, especially in the current budget conscious atmosphere. Passage of S.2229, particularly with respect to Sec. 401, 403 and 405, would send a powerful message to educational institutions grappling with decisions on funding graduate level programs.

We strongly support grants for advanced level traineeships in health administration under Sec. 401 of the Bill, and in other allied health professions under Sec. 405. We also support grants for faculty and curriculum development contained within Sec. 306(b), 403 and 405 of the Bill.

While we also support grants for allied health traineeships at the bachelor's level pursuant to Sec. 404, we oppose the 80% set aside for geriatric training. The "graying of America" will likely create a supply crisis of major proportions in the clinical laboratory science field. Thus, clinical laboratory programs will be faced with the need to produce more practitioners. Student traineeship grants serve as an incentive to institutions to increase recruitment and enrollment efforts. Under the current bill, clinical laboratory science programs would only be entitled to share twenty percent of this grant money with at least 15 other professions. ASMT believes that the allocation of such funds should be more equitably distributed among all segments of the allied health professions.

D. ASMT strongly supports the establishment of an allied health professions data system.

ASMT views Sec. 406 as essential to the profession. There is little empirical data on the supply, utilization and distribution of clinical laboratory scientists. Since clinical laboratory scientists practice in such diverse settings, it has been difficult for any organization to perform a comprehensive study in this profession.

There is an urgent need to identify the number of full- and part-time professionals practicing clinical laboratory science and the settings in which they practice (e.g., POLs, hospital, independent and other laboratory settings). Further, the number of individuals per specialty must be determined to prevent potential shortages. Since comprehensive statistics are lacking, the profession can only guess on issues such as resource placement, demographic distribution and utilization.

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ASPH RECOMMENDATIONS FOR REAUTHORIZATION OF PUBLIC HEALTH TRAINING PROGRAMS (FY 1989-91)

On September 30, 1988, P.L.99-129, the Health Professions Training Assistance Act of 1985 (a.k.a., the health manpower act) expires. The academic public health sections of the act (e.g., capitation, traineeships, etc.) are the oldest federal higher education assistance programs since enactment of the Morrill land-grant act in 1856.

Every study and report, dating back to 1979, has warned of the shortages of public health professionals.

These bleak future assessments, from government studies to academic experts, continue despite a 45% increase in graduates from the 24 U.S. graduate Schools of Public Health between 1974 and 1986.

Indeed, the heightened demand for graduate education in public health and contracted government budgets, points to a deterioration in the quality of instruction or to cuts in enrollment. Perhaps both.

The Department of Health and Human Services, in assessing the status of health personnel, recently declared: "The size, numerical adequacy, training, and competency of the public health work force are matters of direct public concern."**

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* ASPH is the only national organization representing the Deans, over 1,800 faculty and the 9,500 students of the 24 Schools of Public Health. The Schools represent the primary education system that trains personnel needed to operate our nation's public health, disease prevention and health promotion programs. ASPH's principal purpose is to promote and improve the education and training of professional public health personnel. It was formed in 1959 in response to the need to give a national voice to academic public health. See Attachment A for a list of the 24 U.S. Schools of Public Health.

** "Fifth Report to the President and Congress on the Status of Health Personnel in the United States" (1986) by the U.S. Department of Health and Human Services (HHS). For a summary of the report, see Attachment C.

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May 2, 1988

The Honorable Edward Kennedy
Chairman
Senate Committee on Labor and
   Human Resources
Room 527 Hart Building
Washington, D. C. 20510

Dear Mr. Chairman:

As President of the American Society of Clinical Pathologists (ASCP), whose members and registrants exceed 140,000 allied health laboratory professionals, I am pleased to have this opportunity to transmit the views of the Society regarding S. 2229, the Health Professions Reauthorization Act of 1988 for the record. We commend you, your Committee and your staff for your commitment to assisting the health professions schools in providing quality education through federal grants and contracts, and in providing those students enrolled in health professions education programs the opportunity to apply for special loans and other tuition assistance so that they may pursue their education to become health professionals.

The ASCP is a nonprofit medical specialty society organized for educational and scientific purposes. Its membership numbers over 45,000 board-certified pathologists, other physicians, clinical scientists and certified technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel. ASCP's certifying board registers over 140,000 certified laboratory professionals annually.

In our statement, we support Title IV of S. 2229, providing grant/contract opportunities for all allied health programs. Given the manpower crisis in the allied health laboratory profession, these funds will alleviate some of the economic

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The Honorable Edward Kennedy
May 2, 1988
Page 2

problems currently being faced by health professions programs. We also support the expansion of the Health Education Assistance Loan and the Health Professions Student Loan Programs to undergraduate students enrolled in schools of allied health. We bring to your attention, however, the need to change the definition of "schools of allied health" to include hospital based programs. Without this change, students enrolled in hospital based programs would not be eligible to apply for these loans. Students in hospital based programs need this opportunity as much as students in the university programs.

I wish to extend my appreciation to you for your continued concern for the health care needs of our nation and for your excellent leadership in ensuring that these needs are met. The American Society of Clinical Pathologists is prepared to help you in your endeavors.

Sincerely,

George C. Hoffman MD

George C. Hoffman, M.D.
President

Enclosure

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STATEMENT
OF THE
AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS
TO THE
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
RE: S. 2229
HEALTH PROFESSIONS REAUTHORIZATION ACT OF 1988

MAY 2, 1988

The American Society of Clinical Pathologists (ASCP), whose members and registrants exceed 140,000 allied health laboratory professionals, is pleased to have this opportunity to submit its comments for the record on S. 2229, the Health Professions Reauthorization Act of 1988, as introduced by Senate Committee on Labor and Human Resources Committee Chairman, Edward Kennedy (D-MA). The Society applauds the Chairman, other members of the Committee and staff for providing for the first time in over seven years, specific funding opportunities to allied health. This signifies a recognition by the Committee of the need for providing federal assistance to allied health programs to alleviate the manpower shortages presently experienced in some fields and expected in the near future in others. Specifically, it is important to acknowledge that: 1) institutions are having increasing difficulties in recruiting individuals to the allied health professions; 2) all allied health students need opportunities to apply for health professions loans; 3) institutions are facing increased budgetary restrictions; and 4) the federal government does indeed have a role in alleviating these problems by providing financial assistance.

Title IV - Programs for Personnel in Health Administration and in Allied Health

The ASCP supports Title IV of the proposed reauthorization establishing specific grant/contract opportunities for allied health programs. These opportunities are essential to maintain and increase the number of allied health professions in the Nation. Allied health manpower has experienced shortages in the past and will continue to face them in the future. Yet, the manpower demands for these professionals continues to increase. In medical technology, the Department of Labor's Bureau of Labor Statistics has estimated that there will be a 24 percent increase in demand by the year 2000.

There has been a sharp decrease in the number of applicants to allied health education programs. To begin, the overall number of high school graduates continues to decline. The general fear of contracting blood borne diseases such as Acquired Immune Deficiency Syndrome is discouraging many high schools students from choosing careers in the health professions, especially in the laboratory. There is also a perceived lack of upward mobility and earning power in the allied health professions. Finally, the allied health professions have traditionally been dominated by women. A multiplicity of career choices now exists for women.

The problems resulting from all of these changes are somewhat circular: fewer students are entering the field, programs which do not have enough students are closing, students choosing to enter the field may have increased difficulty in the future finding programs that are open. Federal assistance such as the initiatives in Title IV of S. 2229 will ensure that the programs have the financial support to remain open and develop effective recruitment programs.

Title I - Student Assistance

The ASCP also supports Title I of S. 2229, expanding the Health Education Assistance Loan (HEAL) and Health Professions Student Loan (HPSL) Programs. Allied health students also need opportunities to apply for loans. Loan programs under the auspices of the Department of Education--i.e., Perkins Loans--may not be sufficient for students who may be seeking another undergraduate degree or are completing additional undergraduate course work in the health professions. The expansion of HEAL and HPSL included in S. 2229 provides these students with needed assistance. The availability of these additional loan sources will undoubtedly help many students enter or remain in allied health professions training programs. The ASCP commends the Committee for recognizing this need.

Schools of Allied Health

While the ASCP wholeheartedly supports S. 2229, the Society feels that there is one issue which has not been addressed by the Committee which is of the utmost importance to laboratory professionals and other allied health fields. The definition of "schools of allied health" as presently defined by the Public Health Service Act is limited to those programs in universities, colleges, and community colleges. This definition excludes a significant portion of allied health programs--those based in hospitals.

The number of closures of hospital-based allied health programs is drastic. A detailed analysis of those states which have been particularly affected in the fields of Medical Technology and Cytotechnology is attached to this statement. For the state of Massachusetts, 11 out of 19 hospital-based medical technology programs with a collective class cap of 82 students have closed since 1983. Three other hospital-based programs reduced their class caps by a total of 21 students. Class caps at the three university-based programs have not increased. In fact, Northeastern University reduced its class cap by 12. There is now a severe manpower shortage of medical technologists in Massachusetts, particularly in the Boston area. In Hawaii, two of the four hospital-based medical technology programs with a collective class cap of 10 students have closed since 1983. The university-based program has meanwhile reduced its class cap from 85 to 16. These are only a few examples which illustrate the national trend which is emerging.

Other allied health professions will be affected by the limitations on the definition of schools of allied health. Of the 2,843 allied health programs accredited by the American Medical Association's Committee on Allied Health Education Accreditation (CAHEA), 986, or 34.7%, are based in hospitals. There were 32,973 graduates in allied health in 1987, 5,598, or 17%, of whom were enrolled in hospital-based programs. Those allied health professions with a large percentage of CAHEA-accredited hospital-based training programs are: Specialist in Blood Banking Technology (80.9%), Medical Technology (68.5%), Histologic Technician/Technologist (68.3%), Ophthalmic Medical Assistant (66.6%), Cytotechnology (55.3%), Radiographer (54%), Perfusionist (45%), Radiation Therapy Technologist (45%), Diagnostic Medical Sonographer (38%), Nuclear Medicine Technologist (37.4%), and Electroencephalographic Technologist (37%).

Hospital-based programs meet the same accreditation criteria as established by CAHEA as those based in universities. Studies demonstrate that particularly in the laboratory field, students graduating from hospital-based programs perform as well if not better on national certification examinations than those who graduate from a university-based program.

A majority of the hospital-based programs are affiliated with universities. The student attends the university for the first part of his/her education and spends the remaining year(s) of training in the CAHEA-accredited hospital setting. Some students already have a baccalaureate degree before entering the hospital training program. In these situations, the hospital, as a CAHEA accredited program, awards the student a certificate indicating successful completion of the program. For students who have not obtained their degree prior to the hospital program training, the university will recognize the certificate and award academic credit. Hospital-based programs have the same responsibilities in terms of curriculum development, faculty training, etc., as the university programs.

Tuition in hospital-based programs may be as high as in the university-based program. Students enrolled in hospital-based programs need access to loan programs and other financial assistance. They are not eligible to apply for loans presently available under the Public Health Service Act and would not be eligible to apply for HEAL and HPSL under Title I of S. 2229 as presently drafted.

Hospital-based programs face particular financial stress as a result of the Medicare Prospective Payment System (PPS). To account for limited reimbursement for inpatient care caused by the PPS, hospitals are forced to make cuts in areas such as allied health education programs which may not contribute directly to patient care and are costly for the hospital to operate. Medicare's direct pass-through for allied health education is not adequate financial support to keep the program open.

While hospital-based programs are traditionally much smaller than those based in universities, when hospital programs have closed, the universities have generally not expanded to take in extra students. Therefore, the reduction in training slots caused by the closure of the hospital-based program is not made up by the universities. Additionally, some hospital-based programs are located in areas that may not have a local college or university. The only available training program may be in a hospital. Therefore, if the hospital program closes, the student may not have access to a university-based educational program. This is already contributing to a manpower shortage in many geographic locations.

The ASCP recognizes that hospital-based programs are equally eligible to apply for the grant/contract opportunities contained in Title IV of S. 2229. However, as mentioned previously, the expansion of the HEAL and HPSL programs would not apply to student enrolled in hospital-based programs since the program appears to be limited to students enrolled in schools of allied health has defined by the Public Health Service Act. The Society is not positing that hospital-based programs and their students be given extra consideration or grant opportunities. Rather, we request that CAHEA accredited hospital-based allied health programs be treated on a basis equal to other CAHEA accredited allied health programs. These programs and their students should be given the same opportunity to apply for the grants and loans which are available to other allied health institutions and their students.

In light of the foregoing statements, we urge the Subcommittee to consider amending Section 701(10) (42 U.S.C. 292 (10)) of the Public Health Service Act by:

(a) deleting "or" after "college";

(b) after "university," inserting "or other accredited educational institutions--";

(c) in paragraph (B) deleting ";" after "curricula" and inserting in lieu thereof: "except for accredited programs based in locations other than a public or nonprofit private college, junior college, college or university;".

By enacting this change in definition, the Committee is assured that all allied health programs and their students are equally eligible to apply for grants and/or loans made available by the Department of Health and Human Services.

The American Society of Clinical Pathologists applauds the Committee for their interest and keen awareness of the current problems encountered by the allied health professions. We are committed to assisting you in alleviating this problems. We appreciate this opportunity to express our views and would be happy to provide additional information as needed.

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The American Society of Clinical Pathologists is a nonprofit medical specialty society organized for educational and scientific purposes. Its membership numbers over 45,000 board-certified pathologists, other physicians, clinical scientists and certified technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel. ASCP's certifying board registers over 140,000 certified laboratory professionals annually.

STATUS OF MEDICAL TECHNOLOGY AND CYTOTECHNOLOGY PROGRAMS

In 1983, there were 638 accredited medical technology programs throughout out the United States. Of these programs, 484, or 75.8%, were hospital based. Of the 509 programs remaining, 309, or 68.5% of which are hospital based. Also in 1983, there were 66 accredited cytotechnology programs, 37, or 56% of which were hospital based. Of the 47 programs remaining, 26, or 55.3% are hospital based.

Alabama: In 1983, there were 14 medical technology programs, nine of which were hospital based. There are now only nine programs, four of which are hospital based. In 1983, there were two university based cytotechnology programs; only one remains.

Arizona: In 1983, there were three medical technology programs, two of which were hospital based. These two programs closed. A total of 30 student slots were lost. Arizona State University has since opened a medical technology program with 14 student slots, and University Medical Center has reduced its student cap by four slots.

Arkansas: One hospital based program has closed since 1983. One of the university based programs has reduced its class cap by 50%.

California: In 1983, there were 55 medical technology programs, 46 of which were hospital based. There are now only 36 programs, 28 of which are hospital based. A total of 300 slots were lost. Only 50 slots were gained by increases in various programs. Within this same time period, two cytotechnology programs, one of which was hospital based.

Colorado: In 1983, there were eight medical technology programs, seven of which were hospital based. One hospital based program has closed. The university based program did not increase its class cap to make up for the loss.

Connecticut has seven hospital based medical technology programs with a collective class cap of 68 students, and two university based programs with a collective class cap of 40 students. Since 1983, the only hospital based cytotechnology program--class cap of four students--has closed. The only remaining program--university based--has not increased its class cap of four.

Florida gained one university based medical technology program since 1983. The 20 student extra student slots does not, however, make up for the 26 slots lost as a result of closing three hospital based programs. In addition, the other university based programs collectively reduced their class caps by 75.

Georgia has lost two hospital based medical technology programs since 1983. These two programs, plus a reduction in one other hospital based program resulted in a loss of 30 student slots. One university based program opened with a class cap of ten students. Meanwhile, Georgia State University reduced its class cap by 62 students.

Hawaii lost two hospital based medical technology programs with a collective class cap of 10 students since 1983. The university based program has meanwhile reduced its class cap from 85 to 16.

Idaho: All of the medical technology programs are hospital based. In 1983, there were three programs; there is now only one.

Illinois lost 10 hospital based medical technology programs since 1983. Eight other programs reduced their class caps; one, Rush Presbyterian-St. Luke's Medical Center, by 32. Two university programs reduced their caps by a total of 52. Two new university programs opened with only 27 new student slots.

Indiana lost two hospital based medical technology programs with a collective class cap of 38 students since 1983. Also during that time, one of the two university based programs decreased its class cap from 47 to 10 students. The state's only hospital based cytotechnology program closed. The remaining university based cytotechnology program did not increase its class size to lessen the loss.

Iowa lost four hospital based medical technology programs since 1983. The sole university based program has not increased its class cap to make up for the 60 lost slots. The state's only cytotechnology program, a hospital based program, has closed.

Kansas lost two of its five hospital based medical technology since 1983. The two university based programs did not increase its class caps to make up the 28 student slots which were lost. The only hospital based cytotechnology program has closed and the university based program at the University of Kansas has not increased its class cap to make up for the six student slots lost.

Kentucky: Three hospital based medical technology programs have closed since 1983.

Louisiana lost two hospital based medical technology programs since 1983, with a loss of 22 student slots. The program at Southeastern Louisiana University with ten student slots closed, and Louisiana State University Medical Center reduced its class cap by 28. One hospital program opened during this same time period adding ten student slots.

Maine: All of the medical technology programs in Maine are hospital based. They have remained stable over the past five years.

Maryland has lost one hospital based medical technology program with a class cap of 12 since 1983. The University of Maryland School of Medicine has reduced its class cap 50% to 60 students. Columbia

Union College reduced its class cap from 70 to 10 students. Morgan State University opened with a class cap of 10.

Massachusetts lost 11 hospital based medical technology programs with a collective class cap of 82 students since 1983. Three other hospital based programs reduced their class caps by a total of 21 students. Class caps at the three university based programs have not increased. In fact, Northeastern University reduced its class cap by 12. There is now a severe manpower shortage of medical technologists in Massachusetts, particularly in the Boston area.

Michigan: In 1983, there were 35 medical technology programs, 29 of which were hospital based. There are now a total of 26 programs, 21 of which are hospital based. The three cytotechnology programs in the state are hospital based.

Minnesota: Four hospital based medical technology programs has closed since 1983. The two university based programs have reduced their class caps by 65 students collectively.

Mississippi has not suffered any closures since 1983. The three hospital based medical technology programs did not suffer any losses. The program at the University of Mississippi Medical Center reduced its class cap by 50% (25 students). The University also reduced its cytotechnology program, the only one in the state, by 50% (four students).

Missouri lost four hospital based medical technology programs since 1983.

Nebraska: One hospital based medical technology program and one university based program have closed since 1983, leaving two hospital programs and two university programs. The University of Nebraska Medical Center reduced its class cap by 50% to 20 students.

Nevada's only medical technology program is university based. It has reduced its class cap from 120 in 1983, to 30.

New Jersey: Five hospital based medical technology programs have closed since 1983. The only university based programs increased its class cap by six.

New York: In 1983, there were 25 medical technology programs, 17 of which were hospital based. There are now 21 programs, 12 of which are hospital based. One new university program opened during this time period. A total of 57 new student slots were created, while 193 slots were eliminated.

North Carolina: Two hospital based medical technology programs have closed since 1983. Most of the university based programs have significantly reduced their class caps.

Ohio lost 13 hospital based medical technology programs since 1983. One other program decreased its class size by two. During this time, two hospital based programs opened, one hospital increased its class cap by 10, one university based program increased its class cap by four and another university based program opened with a class cap of 12. This results in 60 new slots compared to the 139 slots lost. All of the cytotechnology programs are hospital based; one has closed since 1983.

Oklahoma has lost five hospital based medical technology programs since 1983. The only university based program has reduced its class cap by 50% to 20 students.

In Rhode Island, all of the medical technology programs (five) are hospital based.

South Carolina lost two hospital based medical technology programs--with a collective class cap of 26 students--since 1983. The one university based program has not increased its class cap.

South Dakota: All of the medical technology programs are hospital based. Since 1983, one program has closed.

Texas: In 1983, there were a total of 38 medical technology programs, 25 of which were hospital based. There are now 30 programs, 17 of which are hospital based. Three university programs closed during this time period, but three also opened. A total of 118 student slots were lost, compared to 13 new slots created. In cytotechnology, there were five program operating in 1983; there are now only two.

Utah: Three of the four medical technology programs are university based. The program at the University of Utah reduced its class cap from 50 to 10.

Virginia: One hospital based medical technology program has closed since 1983. Two of the university based programs reduced their class caps by 50%.

Washington: Three hospital based programs have closed since 1983. One has opened. The University of Washington has reduced its class cap by 50% to 50 students.

West Virginia: In 1983, there were seven medical technology programs, three of which were hospital based. There are now four programs, only one of which is hospital based. West Liberty State College reduced its class cap from 48 to 16 students.

Wisconsin: In 1983, there were 31 medical technology programs, 30 of which were hospital based. There are now 19 programs, 17 of which are hospital based. The University of Wisconsin at Madison reduced its class cap by 50% to 48 students. The University of Wisconsin at Milwaukee opened a program with a class cap of only eight students.

--ASCP WASHINGTON OFFICE--
--APRIL 1988--

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April 29, 1988

Stephen Keith, M.D.
Professional Staff Member
Senate Labor Committee
527 Hart Senate Office Building
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Dear Stephen:

Could you make sure that our testimony (attached) on reauthorization of Title VII programs gets inserted into the hearing record?

When questioned by Senator Matsunaga about what HRSA is doing to fill the shortages of public health professionals, Jarrett Clinton, director of BHPr, said that he had no authority to target federal dollars for projects designed to train professionals in fields of national need that were pointed out in the HHS fifth report to Congress on the status of health personnel (see attachment C of our testimony). During mark-up of S.2229, could it be possible to incorporate a provision that would give BHPr authority to target federal dollars to national public health shortage areas? If so, I think our recommendations on the bottom of page 6 and 7 of our testimony might do it. It doesn't have to be $5 million; the new authority could begin with $3 million in FY89, $3.5 million in FY90 and $4 million in FY91.

Your help in this matter would be greatly appreciated. This new provision would also bring some parity to the public health authorities when compared to the large increases S.2229 gives to medicine and allied health.

Thanks.

Sincerely,

Michael K. Gemmell, CAE
Executive Director

Enclosures
MKG/cj

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STATEMENT OF THE
ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH
ON
REAUTHORIZATION OF TITLE VII OF THE PUBLIC HEALTH SERVICE ACT

SUBMITTED FOR THE RECORD

TO THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

U.S. SENATE

Washington, D.C.
April 19, 1988

In that report, HHS asserted that "the Federal government's responsibilities and objectives in the field of health promotion and disease prevention warrant a continued high level of concern for manpower resources in public health. Adequately trained public health professionals, effectively utilized, are essential to progress in prevention of disease, identification and control of environmental health goals."

The areas cited by HHS with shortages of specialists were clear:

- Epidemiologists to deal with non-infectious diseases, new generation infectious diseases (AIDS) and environmental problems
- Biostatisticians competent in the design and implementation of highly controlled studies
- Environmental health professionals, skilled in toxicology and assessing the risks from hazardous chemical and physical agents
- Public health nurses, nutritionists and health educators to deal with the problems of children, the aged and disadvantaged
- Health administrators to address changing cost containment and reimbursement issues

Futhermore, a HHS advisory panel, the Graduate Medical Education National Advisory Commission, projected a shortage of some 1,500 less than the 3,550 public health and preventive medicine physicians needed in the 1990's.

These grim forecasts come at a time when the student population is changing and the graduate faculties are aging.

Between 1977 and 1985 enrollments shot up about 36% to over 9,000.* The faculty, however, over the same period grew only from 1,166 in 20 accredited schools to 1,278 in 24 schools. As a direct result, the student-to-faculty ratio declined to 6.0 in 1985, well beyond the rule of thumb of a ratio of four-to-one for graduate studies.

Equally distressing is the decline of physicians -- down to 17.6% in 1985 -- in academic public health. Of the 24 schools, 17 have two or fewer physicians at the entry level rank of assistant professor. In critical supply are physician educators trained in preventive medicine, epidemiology, biostatistics and toxicology.

At the same time many health science students are shunning careers in public health because of the wrenching 60% cut in traineeships since 1981 and the high costs of taking out HEAL loans. The field is not attracting an adequate number of physicians, engineers, nurses, chemists and physical scientists. The trickle of engineers that entered public health through the mid-1970s has all but dried up. There have also been a decrease in veterinarians entering the field.

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* Over 10,000 graduate public health students will be enrolled in 1988 in the 24 Schools of Public Health.

State health officers are particularly alarmed about the low number of nurses trained at the graduate level in public health.

The "West Point of Health" is what President Eisenhower dubbed the schools in 1958, when he signed legislation recognizing the education of public health leaders as a Federal responsibility to be shared with the schools. Indeed, it was pointed out at the time that if the schools had not existed, the public health equivalent of a military academy would have had to be created.

For nearly 30 years a Federal responsibility has been recognized in a partial reimbursement of the cost of educating these public health leaders. The majority (80 percent) of these graduates work in the public or non-profit sector, where salaries are modest by any measure. In 1982, a survey by the Association of Schools of Public Health, found that the median income of graduates was only $21,600. By 1986 the median income was only $28,000 (see attachment B) for these highly qualified and vital public service professionals, hardly competitive with the private sector.

Consequently, the ASPH is incredulous that the Administration would recommend the end to Federal support for public health graduate education as it has over the past decade. Given the current federal budget deficit, certain reductions in spending are justified. But to terminate programs that promote health and prevent disease (e.g., public health training), only adds to that deficit. It's a commonly held belief that prevention saves, both lives and money.

Following are the recommendations of the ASPH for FY1989-91 reauthorization of public health manpower training programs.

Capitation

At a time when the nation is transfixed by AIDS and environmental hazards are routinely uncovered, the 24 graduate Schools of Public Health find themselves at a critical juncture.

Since Federal assistance to the schools, or "capitation", began in 1956, enrollments have soared, so that a fivefold increase to 10,000 students is expected in September, 1988. The growth in faculty, unfortunately, has not kept pace. In 1985, with a faculty of 1,278 in the 24 schools, the student-to-faculty ratio declined to 6.0, well beyond the four-to-one rule of thumb for graduate studies.

For the schools and the students this raises the risk that the quality of instruction will deteriorate, that enrollments will have to be cut, or both.

At the national level, the Administration proposes to eliminate authorization for capitation, which expires September 30, 1988. The average capitation award for FY 1987 was $208,000 or $675 per student. These capitation awards are far less than 10% of each school's education and training budget and are generally used to supplement existing educational programs.

The Administration's proposal comes against a backdrop of continued contraction of state and institutional support for these schools, despite the heightened demand for added manpower to meet shortages in the field that have been repeatedly predicted for nearly a decade.

Also of critical importance to national policy is a reduction in the time available for research by faculty and students due to the increased instructional load.

The increase in the body of knowledge of prevention technologies is heavily dependent upon the research activities within these schools. It is within this environment that many expert investigators conduct their studies of ill and well populations.

Equally distressing is the dramatic decline in the number of young physicians choosing careers in academic public health. In 1985, 17 of the 24 schools had two or fewer physicians at the entry level of associate professor. Indeed, ten of the schools had no physicians at the entry level and three had only one.

If the nation is to benefit from the surplus of physicians in the 1990's they should be induced into the public health sector. However, if there are few physicians, young or old, to serve as role models the inducement will be greatly diminished.

Specifically, HHS has warned of both faculty and research shortages in high-priority areas including: chronic disease, behavior and environmental epidemiology; biostatistics; and environmental toxicology, including risk assessment of chemical and physical agents. In short supply, among faculties as well in the work force, are public health nutritionists, occupational health specialists; and analytical scientists, such as mathematical statisticians, biostatisticians, and computer specialists.

The Schools are not attracting enough physicians, nurses and engineers to meet the need for these professionals in public health.

These graduate students are typically mid-career professionals, for whom an advanced degree does not lead to a lucrative salary. The median age is 31, and a large percentage are part-time students, already at work in the public sector.

Adding futher to the problem is the fact that teaching costs are about $14,000 a year and approximate those of some medical schools.

The Association of Schools of Public Health requests capitation authorizations of $8 million in FY 1989, $10 million in FY 1990, and $12 million in FY 1991.

Traineeships

Student support, through "traineeships", is intended to attract economically disadvantaged and high caliber students to the field. The rising costs of graduate education will make it even more difficult for low-income students, especially minorities, to afford graduate education in public health.

Traineeships also offer the opportunity for students to be placed in public health agencies in order to incorporate practice experiences into public health education.

It should be noted that students in Schools of Public Health are not eligible for the Health Professions Student Loan program, as are most students in other schools of the health professions.

An ASPH survey found that more than 50% of the 1986 graduates relied on traineeships, loans, or some other type of financial assistance to meet their educational expenses. As was pointed out, graduate education in public health is not pursued to dramatically improve one's salary position. The survey found that one-half of the 1986 graduates earn less than $28,000 annually, and the mean income was $31,524. These figures include physicians and dentists working in public health. In addition, many undertake graduate education with important family obligations. The survey found that 60% of the 1986 graduates reported education-related indebtedness, a median debt of $10,000.

About 80% of the graduates work in governmental health agencies, universities, or for non-profit health organizations (see Attachment B).

The ASPH requests $5 million for FY 1989, $6 million for FY 1990 and $7 million for FY 1991 for traineeships to students in Schools of Public Health.

Preventive Medicine and Public Health Residencies

The campaign for Americans to change their diets to reduce cholesterol; and to quit smoking to reduce the risks of cancer and heart disease, stand out as vivid examples of prevention strategies that have improved the public's health.

But a study by an HHS advisory panel has sounded the alarm that by 1990 there could likely be a dramatic shortage of some 1,500 of the needed public health and preventive medicine physicians. An expected shortage in this area was again cited by HHS in its March 1986 report to Congress and the President. The Institute of Medicine recently added its voice to the call for an increase in the number of residencies in preventive medicine.

Remarkably, medical schools do not teach prevention. As a result, physicians are not trained to understand the potential of prevention and the impact it can have on the health care system and cost containment.

Therefore, funding for residencies is needed to promote an awareness of prevention within the medical profession.

The ASPH requests authorizations of $3 million for FY 1989, $4 million for FY 1990, and $5 million for FY 1991 to support residency training for students of preventive medicine in Schools of Public Health and medical schools with accredited departments of preventive medicine.

Health Personnel Data and Manpower Projections

It has become imperative that a centralized system of data collection be continued because of the demands being placed on the Schools of Public Health to provide data to the executive and legislative branches of the Federal government.

Because of the need for accurate data, promptly produced, federal funding is necessary to monitor public health manpower production in the Schools of Public Health as well as in the other health professions schools.

The ASPH urges adequate support in the new health manpower act for projects to collect, compile and analyze data on health manpower.

Special Projects

The ASPH urges authorization of special project grants to enable the accredited schools to stay current with technological and scientific advances in public health, and biomedical and behavioral science fields.

The special projects program is intended to aid Schools of Public Health to develop new programs and expand existing ones in biostatistics and epidemiology, health care cost control and policy analysis, maternal and child health, environmental and occupational health, dietetics and nutrition, behavioral science, aging and strategies for health promotion and disease prevention.

Special projects will be used to incorporate public health practice and reality-based skill development into the basic public health curricula.

The project grants would provide support to develop training opportunities in public health to meet emerging national priorities for public health manpower competencies. These include training leaders for management and specialized responsibilities in new and projected health areas such as:

- AIDS
- Epidemiology of sexually transmitted diseases
- Geriatrics
- Alcoholism/drug abuse prevention and control
- Toxicology/environmental health
- Health care cost containment
- Health promotion/disease prevention
- Nutrition
- Injury due to accidents within and outside the workplace

Project grants are targeted to federal initiatives that are stimulating a growing demand for public health personnel. It is likely that demand for public health manpower will increase as a result of current and futute legislative initiatives stressing health promotion and disease prevention as a means of improving the quality of life and reducing health care costs through an increased capacity to administer and manage health programs.

Special project grants would provide the basic generic support for improving the quality of the curriculum in public health, disease control, and health promotion. Emphasis will be placed on projects designed to train professionals in fields of national need as outlined in the HHS "Fifth Report to the President and Congress on the Status of Health Personnel in the U.S." (see Attachment C)

The ASPH requests $5 million for FY 1989, $6 million for FY 1990, and $7 million for FY 1991 to support special projects for faculty and curriculum development in Schools of Public Health.

Summary

The vitality of a nation can be measured in part by the health of its people.

The work of public health has provided some dramatic results in recent years. Polio, the childhood scourge of the 1950s, has been nearly eliminated. The worldwide eradication of smallpox is another example of public health practice at work. Death rates from heart attacks and strokes have been reduced by more than 1/3 since 1970. Environmental and occupational hazards have been identified and reduced.

Adult Americans, for the first time in history, are gaining about two years of life per decade. Children born in 1984 have an average life expectancy at birth of 74.7 years, a gain of nearly three years since 1974. Yet the AIDS threatens to block futher advances in health status. We don't have adequately trained health professionals to deal with this threat.

Congress enacted Superfund to clean-up the environment. Yet there is a shortage of trained technical people needed for site clean-up and hazardous waste management.

This shortage is only symptomatic of shortages in the public health field that have been perceived or documented in a litany of reports.

The Department of Health and Human Services, in its Fifth Report to Congress, maintained there are insufficient public health professionals prepared to cope with new and emerging public health problems (see Attachment C). These problems were outlined as behavior-related disorders; work-related diseases and injuries; new and re-emerging communicable diseases; the special problems of the aged, children, migrants, immigrants and the poor; toxic waste and other environmental issues, along with the prevention of chronic diseases such as cancer, heart disease, stroke, and dementia of the Alzheimer type.

While these problems are being dealt with by the public health system, it is a system under strain.

Faculty shortages first pointed to by the U.S. Surgeon General in 1979 still loom large, especially in occupational and environmental health, epidemiology, biostatistics, nutrition and geriatrics.

Enrollments in the Schools of Public Health have increased, but the number of physicians choosing academic public health as a career has not kept up to traditional standards.

The increased interest in graduate education has also increased the student-to-faculty ratio, risking a deterioration of the quality of education or cuts in enrollment, or both.

Public health is a national responsibility. Schools of Public Health train personnel for public service. The Federal government has a direct interest in assuring that an adequate supply of public health personnel is trained in quality institutions to manage and operate the health delivery system in the national interest.

The ASPH believes that continued Federal assistance is actually an investment at the front end of the health care system. The schools, through their educational efforts, not only will help prevent illness, but also will help slow down the rapidly escalating costs of medical care.

Finally, ASPH justifications for Federal institutional, student and special project support are based on the fact that even though there will likely be an overall surplus of physicians by the year 2000, continuing shortages are expected in the supply of preventive medicine physicians, toxicologists, public health practitioners, occupational and environmental physicians, public health nurses, nutritionists, epidemiologists, biostatisticians, among others. These professionals are trained in the 24 U.S. Schools of Public Health.

In the past, the Administration has recommended that the authorities for providing assistance to Schools of Public Health be terminated. The rationale for this recommendation was that state resources would be available to the schools and that student assistance would be available through other sources.

However, this is not the case. Stable support for Schools of Public Health, other than legislative support under the Public Health Service Act, is simply not available.

It does not make sense for the Federal government to foster programs that will require substantial numbers of public health professionals without insuring that financial resources are available to provide for the competent training of such personnel.

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ATTACHMENT A
ACCREDITED SCHOOLS OF PUBLIC HEALTH

University of Alabama at Birmingham
Boston University
University of California, Berkeley
University of California, Los Angeles
Columbia University
Harvard University
University of Hawaii
University of Illinois at Chicago
Johns Hopkins University
Loma Linda University
University of Massachusetts
University of Michigan
University of Minnesota
University of North Carolina
University of Oklahoma
University of Pittsburgh
University of Puerto Rico
San Diego State University
University of South Carolina
University of South Florida
University of Texas
Tulane University
University of Washington
Yale University
State University of New York at Albany
(will seek accreditation in 1990)

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ATTACHMENT B

ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

HIGHLIGHTS OF THE DATA ON 1986 GRADUATES

Surveyed in February 1987

Employment

82.1%	of the graduates are employed
11.5%	of the graduates are continuing their education
5.0%	of the graduates are unemployed and seeking employment

Type of Employing Organization

47.1%	of employed graduates work for tax-supported organizations such as federal, state, regional or local government (including state supported higher educational institutions)
32.8%	of employed graduates work for voluntary (non-profit) organizations
18.9%	of employed graduates work for proprietary (for-profit) organizations

Types of Services Which Graduates are Providing

35.8%	of graduates are providing administrative, planning or evaluation services
18.6%	of graduates are providing clinical, laboratory, or social services
14.6%	of graduates are providing education or research services to students
7.3%	of graduates are providing public health community organizational services
11.0%	of graduates are providing consultation services

Earning Levels of Employed Graduates

50%	of employed graduates earn less than $28,000 per year

Financial Assistance During Training

25.8%	of graduates depended on traineeships, scholarships, fellowships or grants as the primary source of funds for meeting educational expenses

22.2% of graduates depended on employment earnings as the primary source

21.5% of graduates depended on loans as the primary source

Education Related Indebtedness

60% of graduates reported some amount of education-related indebtedness. The median indebtedness for these graduates was $10,000. In addition, 41% reported that they already had education-related indebtedness when they entered their school of public health.

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ATTACHMENT C

Excerpts from the DHHS

FIFTH REPORT TO THE PRESIDENT AND CONGRESS ON THE STATUS OF HEALTH PERSONNEL IN THE UNITED STATES (1986)

Public Health Shortages (in general)

Although supply and requirements for public health personnel cannot be discussed with the same precision as other health professions, existing studies and prevailing professional judgments point to several occupations with personnel shortages and other occupations in which qualified personnel are difficult to recruit. There are perceived shortages of epidemiologists, environmental health professions including toxicologists, biostatisticians, nutritionists, public health nurses, and physicians trained in public health and preventive medicine. Studies are under development to verify these perceived shortages (page 11-9).

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Specific Shortages

DHHS workshops in 1981 and 1982 (DHHS, 1982) and follow-up reports in 1983 and 1985 (Magee, 1983; Brown, 1985; Greenberg and Magee, 1985) confirmed these findings and suggested the following areas need increased production of highly trained public health specialists:

- Epidemiologists who can deal with noninfectious disease and trauma, particularly those of environmental and behavioral origins
- Environmental health professionals trained in toxicology and assessment of the risks associated with hazardous chemical and physical substances
- Biostatisticians competent in the design and implementation of highly controlled studies
- Nutritionists trained in public health, especially at the doctorate level, who can function as researchers and faculty members

Page 2/

- Health administrators educated to address changing cost containment and reimbursement issues
- Nurses with a public/community health orientation, who can identify high-risk groups, work with community organizations in prevention programs, and deal with the special needs of the elderly, chronically ill and disadvantaged
- Physicians trained in public health and preventive medicine

It is recommended that the schools need to pay closer attention to the types of students they seek. The recruitment of physicians, other health professionals, scientists, and engineers in related disciplines -- that is, individuals with backgrounds best suited to contribute to public health work -- is lagging (page 11-18).

****

Public Health Physician Shortages

The shortage of physicians and certain scientists (e.g., nutritionists and toxicologists) opting for advanced public health training is a major issue. Their scientific and technical backgrounds, when coupled with graduate preparation in the public health sciences, uniquely qualified them for leadership in practice, research, and faculty roles identified as being in short supply.

Shortages of physicians in public health are likely to continue. The number of physicians who regard themselves as primarily working in preventive medicine has declined steadily in recent years (page 11-18).

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Training Current Worker Needs

In 1980 it was estimated that of a primary public health work force of approximately 250,000 individuals, about 25 percent had graduate training in public health. Estimates for 1985 suggest that approximately 75,000 personnel or about 30 percent have such training. Although precise data are not available, experts contend that large proportions of the environmental health, public health nursing, nutrition, and health education personnel currently in the work force have not received formal basic preparation in public health principles, theory, and methods...It is recommended that increased emphasis be given to professional development programs for practicing public health professionals (page 11-19).

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Page 3/

Shortages of Faculty

The Bureau of Health Professions' 1981-82 workshop series on public health personnel (DHHS, 1982) identified a shortage of qualified faculty and researchers with expertise in a number of high-priority subject areas. Faculty and researchers in chronic disease and environmental epidemiology, toxicology, and risk assessment of chemical and physical agents in the environment are reported to be in high demand and low supply. Difficulties in recruiting physicians for faculty positions in public health are also reported. A second group expected to be in short supply in university faculties includes nutritionists, occupational health specialists (nurses, industrial hygienists), and analytical scientists (mathematical statisticians, biostatisticians, and computer specialists). In each of these groups, competition between universities and private industry is expected to be keen, particularly for those with extensive training and experience. Salary differentials between universities and industry suggest that the recruitment problems of academic and research institutions will continue. It is therefore recommended that approaches be developed to address the recruitment and retention gap of highly skilled faculty and researchers (page 11-20).

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Curriculum Development Needs

In September 1984 a series of five workshops was conducted by the Bureau of Health Professions to develop recommendations for training health professionals to be more effective in health promotion and disease prevention activities...The recommendations addressed the following areas: increasing the effectiveness of faculty in teaching preventive concepts; developing curricula to allow more meaningful material in didactic and experiential education; selecting students who demonstrate positive attitudes and behavior toward health promotion and disease prevention; including these concepts in accreditation standards and certification and licensure examinations; expanding research in this area; and developing closer links between industry and the health profession education community. The recommendations represent a comprehensive strategy for health profession educators to address health promotion and disease prevention concepts through the educational process. It is recommended that the strategy of incorporating health promotion and disease prevention concepts in the education of health professions (as proposed by five workshops in 1983) be implemented (page 11-21).

The
Association of
Chiropractic
Colleges

EDUCATION
RESEARCH SERVICE

April 7, 1988

Senator Edward M. Kennedy, Chairman
Committee on Labor and Human Resources
428 SDOB
Washington, D.C. 20510-6300

Dear Chairman Kennedy:

In lieu of oral testimony please permit the Association of Chiropractic Colleges to submit these brief comments as your committee approaches mark-up of the reauthorization of Title VII of the Public Health Service Act.

The Association is comprised of 15 colleges with a current enrollment of nearly 10,000 students. Our accrediting agency is The Council on Chiropractic Education, recognized by the U.S. Department of Education.

First, we commend and agree with your approach in S.2229 to reauthorizing all the programs in Title VII. The Administration's budget proposals likely would reduce the adequacy in numbers and training for needed health professionals. We urge continued funding with increases where your committee deems necessary.

At present our colleges participate only in the Health Education Assistance Loan program. We are a big user of these loans: First in numbers of borrowers, second to dentistry in dollars borrowed, and soon to be exceeded by allopathic medicine if data from the latest fiscal year are maintained.

The Association recognizes and supports the need to be good stewards of these dollars, even if the program does not require a federal appropriation. Along and together with the other health professions associations, we are working diligently to achieve the lowest default rates possible at a time when finally all borrowers in all disciplines come into repayment status.

Chiropractic colleges this year have begun to see some of the necessary progress needed to reduce defaults further. The latest HEAL Program Operations Report(October 1, 1986 through September 30, 1987) shows our claims having decreased modestly. We anticipate establishing rates comparable to other federal education lending programs where our performance is generally below the average rate of claims paid for defaults.

Much of the success in turning around default rates in the HEAL program should be given to the Division of Student Assistance in the Bureau of Health Professions. They drew attention to the problem, met with financial aid officers in the disciplines and have shared ways in which program management can run efficiently. We urge your continued support for administering the HEAL program; we have urged the agency to refine their method of defining defaults to allow for not continuing to count defaulters once they have successfully entered again into payment.

REQUEST

For the Association of Chiropractic Colleges the problems to be solved and the opportunities to be claimed are the same as for other educational institutions served through Title VII.

Our students are being asked to assume increasing debt burdens to finance their educations and our colleges are finding it increasingly difficult to attract minorities.

For those programs in Title VII which are intended to help students complete a health professions education of their choice, and for the colleges to serve the range of those students in our society, including the disadvantaged, our colleges need to be full participants under the law.

To achieve this full participation, and service, we respectfully ask to be made eligible for the Health Professions Student Loans under Subpart II, Sec. 740-747; Scholarships to meet Exceptional Financial Need under Subpart V, Sec. 758, and Stipends for Educational Assistance to Individuals from Disadvantaged Backgrounds, Sec.787(a)(2)(F).

We thank you for considering this request. You have the gratitude of this nation for the dedication you and your committee give to our health needs.

Howard E. Holcomb

Statement of the

AMERICAN SOCIETY FOR CYTOTECHNOLOGY

to the SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES

"Health Professions Education Reauthorization Act of 1988"

Redefinition of "School of Allied Health" Critical to Training Programs:

The American Society for Cytotechnology (ASCT) is asking the Committee to redefine "school of allied health" to include hospital-based educational programs. The current definition under Title VII of the Public Health Service Act, Section 701 (10) only includes university-based programs. Hospital-based programs contribute significantly to the allied health workforce and therefore must be eligible for funding for recruitment and curriculum development.

The ASCT is also asking the Committee to delete Section 701 (10)(b) where school of allied health is further defined as "providing training for not less than a total of 20 persons." All educational programs in cytotechnology, hospital and university-based, are accredited for less than 20 persons. This means none of the hospital based programs fit the definition of a school of allied health and therefore their students would not be eligible for loans under the Health Education Assistance Loan program.

Shortage of Qualified Cytotechnologists:

The number of training programs in cytotechnology has sharply dropped from 118 in 1970 to 39 active programs in 1988. Lack of funds to support these programs and inadequate recruitment efforts are the major reasons for this decline. Consequently, only 131 cytotechnology graduates are expected in the US this year (American Society of Cytology, Subcommittee on Student Recruitment,1988).

There are 16 hospital-based programs with the potential to produce 113 graduates per year that are currently offering training in cytotechnology. These programs represent almost half the total number of cytotechnology educational programs. There is a critical need to support recruitment efforts of these programs, as our profession is facing a serious shortage of qualified cytotechnologists.

Effects of Cytotechnologist Shortage:

Meanwhile, the American Cancer Society (ACS) and the National Cancer Institute are promoting massive screening campaigns to improve early cancer detection rates. This means more and more women are being urged to get Pap smears. The ACS now says women in high risk groups should get Pap smears annually. If their smears are negative for three years, the frequency of Pap smear testing thereafter can be decided by their physicians. Other professional organizations (ASCT, ASCP) are recommending annual testing because a significant number (estimated 20%-30%) of cervical cancers can develop into life-threatening invasive disease in less than a year (Am.J. Obstet. Gynecol.146:370,1983).

The recent media reports questioning the reliability of Pap smear testing and the resulting government investigation into this problem directly relate to the number of qualified cytotechnologists. Poor working conditions where cytotechnologists are pressured to review large numbers of Pap smears for low pay has resulted in cytotechnologists leaving the profession. They are finding positions where they can receive better pay and not be at risk of making diagnostic errors which may have devastating effects on patient lives.

State and federal governments are seriously considering adopting and enforcing workload guidelines which will limit the number of Pap smears a cytotechnologist can review within a 24 hour period.

April, 1988

The bottom line is: the number of cytology specimens is rapidly increasing while the number of qualified cytotechnologists to evaluate them is just as rapidly decreasing. More patients will risk misdiagnoses if this disproportionate equation is not balanced.

Training-Expansion Potential Possible in Hospital-Based Programs:
In order to cope with the increasing number and variety of cytology specimens, ASCT Past-President and cytology educator, Shirley E. Greening foresees educational curricula may need to change to offer "specialist training". She says, "School will have to allow for the possibility, if not the inevitability, of offering multidisciplinary training, with multiple training options and multiple entry-exit levels for students who choose different directions in the job market." (ASCT News. V,No.7:47-48,56-58, 1984). For example, a "gynecologic cytotechnologist" would work in a large independent laboratory which processes primarily Pap smears or a "cyto-histotechnologist" would be able to evaluate Pap smears and process tissue specimens.

The funding necessary for these programs to develop curricula for specialist training, again, justifies their eligibility for federal support.

Numbers of Students Eligible for Hospital-Based Programs are Significant:
The hospital-based programs appeal to a special group of students not attracted to university-based programs- those already possessing a bachelor's degree. It is senseless for them to attain a second bachelor's degree. Many of these students, having their degree in biology, are looking for a technical training program in which they can use their biology background and obtain a marketable skill. Hospital-based cytotechnology programs provide this opportunity. Students complete 12 months of specialized training in cytotechnology and are ready to join the workforce at the completion of the program.

The number of individuals eligible for these hospital-based programs is great- every biology major who is interested in a diagnostic medical laboratory career. Most of these students are aware of career opportunities in Medical Technology and most are unaware that cytotechnology also offers a career in the medical laboratory. An extensive educational campaign describing the profession and and the training requirements directed to these individuals is essential. Media development needed to effectively implement such a campaign will require funding not currently available in most hospital budgets. Some funds are available to these programs through Prospective Payment Pass-Through, but realistically, little if any ever trickles down to allied health programs. These hospital-based programs have no other resources, therefore it is critical that they be eligible for funding under the proposed Reauthorization Act.

Hospital-Based Program vs University-Based Program: Quality of **Education is Equal.**
The following profile of hospital-based programs versus university-based programs demonstrates both programs provide quality education:

Factors affecting Quality Education		Hospital-based	University-based
1.	Bachelor's degree	Required upon entry	Granted at program completion
2.	Accreditation	Approved by AMA (CAHEA)	Approved by AMA (CAHEA)

3. AMA Guidelines on Educational Quality	Abides by Essentials	Abides by Essentials
4. Eligibility for Certification	ASCP registry eligible	ASCP registry eligible
5. Maintains Educational Quality	Inspected for CAHEA by ASC* every five years	Inspected for CAHEA by ASC every five years

* American Society of Cytology

Summary Statement:

Redefinition of "school of allied health" to include hospital-based allied health training programs is essential. Eligibility for federal funding for all allied health programs in general, and, cytotechnology programs in particular, will be a major step toward assuring quality in health care because:

1. Approximately half of cytotechnology training programs are hospital-based.
2. The number of training programs in cytotechnology has diminished greatly.
3. The number of working cytotechnologists is currently inadequate to provide accurate review of cytologic specimens.
4. Funding eligibility for a massive recruitment effort is essential.
5. Funding eligibility for curriculum development for the "gynecologic cytotechnologist specialist" is essential.

The American Society for Cytotechnology will work with the Committee to promote quality practice in laboratory testing.

AAPA
AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS
1117 North 19th Street • Arlington, Virginia 22209 • 703/525-4200

May 11, 1988

The Honorable Edward M. Kennedy
Chairman
Labor & Human Resource Committee
SD - 428 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Kennedy:

On behalf of the American Academy of Physician Assistants and the 18,000 physician assistants we represent nationwide, I want to thank you for this opportunity to present our views on S. 2229, a bill to reauthorize health professions educational assistance.

The following constitutes our formal comments submitted for inclusion in the public record of the hearing you conducted on April 28 on reauthorization of health professions educational assistance.

As you well know, health professions educational assistance programs under Title VII of the Public Health Service Act have made it possible for many deserving young men and women to obtain a health professions education who might otherwise have been denied such an opportunity.

More specifically, Section 783, grants to physician assistant programs, has not only helped the PA profession grow and expand but has also helped programs develop and maintain an educational experience that insures that graduates select careers in those practice settings and specialties of greatest need.

The Academy is concerned that should the PA grants program be discontinued, as your bill proposes, many well-qualified individuals will be "locked-out" of the physician assistant professions. In addition, the lack of federal assistance will have a dramatic impact on the job choices future PAs will make.

As the Labor & Human Resources Committee assesses the impact of PA program grants, we hope you will keep several points in mind:

1. There is presently a severe shortage of physician assistants throughout the country.

2. Physician assistants have exhibited a willingness to work in those urban and rural communities designated as medically underserved.

3. The overwhelming majority of physician assistants are in the primary care/family medicine areas.

4. More than 20 percent of all PA students are minorities.

5. 30 percent of all PAs practice in rural communities.

Shortage of PAs

The Association of Physician Assistant Programs (APAP) recently conducted a survey of physician assistant programs to ascertain the current job market for physician assistants. Prior to this survey, there had only been anecdotal information regarding a shortage of physician assistants.

The average jobs/graduate ratio is 7.5 jobs per graduate. This is consistent with the findings of the Department of Labor's Bureau of Labor Statistics which recently reported:

> "Employment of PAs is expected to grow much faster than the average for all occupations through the year 2000 due to anticipated expansion of the health service industry and greater reliance on PA's to provide primary care and assist with complex medical and surgical procedures. Prospects for newly trained PAs are excellent since demand is expected to outstrip supply."

Rural/Urban Medically Underserved Areas (MUAs):

According to the Office of Technology Assessment (OTA), in a December, 1986 report to Congress, "PAs have also contributed notably to improved geographic access to care." A significant percentage of physician assistants are working in rural and urban medically underserved communities. Whereas 27 percent of the general population and 14 percent of physicians are located in rural areas (defined as non-SMSA), more than 30 percent of all PAs are located in these communities.

In addition to choosing practices serving disadvantaged populations, PAs have also shown great consistency in opting for primary care specialties. According to our own masterfile survey, 65 percent of all physician assistants work in a primary care specialty (Internal Medicine, Ob/Gyn, Pediatrics, Family Medicine, etc.).

Furthermore, 11 programs have specific initiatives which benefit inner-city medically underserved populations. Right here in the District of Columbia, for instance, Howard University puts all of its PA students through a clinical rotation providing health care to homeless individuals in the District. Other PA programs offer clinical rotations at chemical dependency programs, adolescent pregnancy clinics and sexually transmitted disease clinics. More recently, programs have expanded to include AIDS education as part of the curriculum.

Under the present PA program grant criteria, grant monies are used to train PAs for the delivery of primary care in ambulatory care settings, place graduates in medically underserved areas, and recruit residents of medically underserved areas, minority groups and women to enter the PA profession. These criteria are a major factor in why PAs are still being found in rural and urban medically underserved primary care settings.

Minority Recruitment:

PA program grants have also been a successful mechanism for recruiting minorities into the PA profession. We have seen a steady rise in the number of minorities attending PA programs culminating in 1986/87 with over 20 percent of PA students being classified as minorities. This figure compares favorably with the numbers evidenced in 1983 when minorities represented 13.8 percent of all PA students. Again, we believe the PA program grants have been a major reason for this rather dramatic rise in minority enrollment.

Impact of Discontinuation:

Should PA program grants as a separate "categorical" grant be eliminated and replaced with the "block" grant approach proposed in S. 2229, we fear that many of the gains evidenced over the past several years will be negated.

If PA programs are going to be required to compete with large medical centers and teaching hospitals, as would occur under your proposal, then we feel certain very little money will ever make its way to the PA profession.

PA programs tend to be small, with small staffs, not well-known for their grant writing ability. Quite frankly, they focus their attention on producing qualified health care providers.

If, in fact, PA programs lose out in the block grant approach, we will not see the demise of the profession, but we will probably see a notable change in its make-up. Minority enrollment will go down, and PAs will probably be attracted to the high priced specialties in much the same way physicians have been attracted to specialties. Tuitions will undoubtedly rise and many of the expensive "off-site" clinical rotations in rural MUAs and urban MUAs will be eliminated.

Conclusion:

Reauthorization of PA program grants is particularly important at this time in history. Those practice settings and specialties traditionally served by PAs are finding it increasingly difficult to attract and retain qualified physician assistants. The increased demand has been particularly acute within the public health community. The Bureau of Prisons and Indian Health Service have both reported a significant shortage of PAs.

The shortage of PAs has also been quite noticeable at the hospital level. Hospitals are exhibiting unprecedented interest in hiring physician assistants. The evidence seems to indicate that this increased demand is directly related to changes in other federal health programs, particularly the cut-backs in Graduate Medical Education (GME).

In light of the widespread recognition that the demand for health care (particularly primary care) will increase as our population ages, now is not the time to eliminate the very program that has been so successful at producing primary care providers.

PA programs have shown a willingness to structure the PA educational experience to the needs of the community. Consequently, tremendous efforts have been made to improve the geriatric component of PA programs, expand home health care rotations and place increased emphasis on health promotion and disease prevention as part of the core curriculum.

As the Subcommittee proceeds with its deliberations on the future of health professions educational assistance under Title VII, we trust you will keep this in mind. Failure to reauthorize program grants would have significant implications on the PA profession, but more importantly, it would have a profound impact on the ability of millions of individuals to have access to quality health care.

The Academy strongly urges you to continue PA program grants as they are presently structured. We look forward to working with you and your staff in the coming months on this most important issue.

Sincerely,

F. Lynn May
Executive Vice President

Senator Matsunaga. The Committee stands in recess subject to the call of the Chair.

[Whereupon, at 4:37 p.m., the Committee was adjourned.]

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